MALAWI NATIONAL HIV PREVENTION FRAMEWORK

2023–2027

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Acronyms

AGYW	Adolescent girls and young women
AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretroviral
BBSS	Biological and Behavioural Surveillance Survey
CBO	Community-based organization
CDC	U.S. Centers for Disease Control and Prevention
CFSW	Client of female sex worker
CHAI	Clinton Health Access Initiative
CHAM	Christian Health Association of Malawi
DHA	Department of HIV and AIDS and Viral Hepatitis
DHS	Demographic and Health Survey
DHRMD	Department of Human Resource Management
DIC	Drop-in centre
EID	Early infant diagnosis
EIMC	Early infant male circumcision
EMTCT	Elimination of mother-to-child transmission
FBO	Faith-based organization
FSW	Female sex worker
GBV	Gender-based violence
GoM	Government of Malawi
GPC	Global HIV Prevention Coalition
HCW	Health care worker
HEI	Higher education institution
HIV	Human immunodeficiency virus
HIVST	HIV self-testing
HMIS	Health management information system
HPV	Human Papillomavirus
HTS	HIV testing services
KP	Key population
M&E	Monitoring and evaluation
MANASO	Malawi Network of AIDS Service Organizations
MANET+	Malawi Network of People Living with HIV
MBCA	Malawi Business Coalition against AIDS
MBTS	Malawi Blood Transfusion Service
MC	Male circumcision
MDHS	Malawi Demographic and Health Survey
MIAA	Malawi Interfaith AIDS Association
mHealth	Mobile health
MOH	Ministry of Health
MPHIA	Malawi Population-Based HIV Impact Assessment
MSM	Men who have sex with men
MSW	Male sex worker

NAC	National AIDS Commission
NCD	Noncommunicable disease
NGO	Nongovernmental organization
NSP	National HIV and AIDS Strategic Plan
NYCOM	National Youth Council of Malawi
PE	Peer educator
PEP	Post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PITC	Provider-initiated testing and counselling
PLACE	Priorities for Local AIDS Control Efforts
PLHIV	People living with HIV
PMRA	Pharmacy Medicines Regulatory Authority
PMTCT	Prevention of mother-to-child transmission
PN	Peer navigator
POC	Point of care
PPP	Public-private partnership
PrEP	Pre-exposure prophylaxis
PSM	Procurement and supply chain management
PWID	People who inject drugs
RIV	Requisition/issue booklets
SBCC	Social and behaviour change communication
SEM	Social-Ecological Model
SMS	Short message service
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
T=T	*Tizirombo tochepa = Thanzi*
TasP	Treatment as prevention
TB	Tuberculosis
ToC	Theory of change
Trans	Transgender
TWG	Technical working group
U=U	Undetectable=untransmissible
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Family Planning Programme
VL	Viral load
VMMC	Voluntary medical male circumcision
WHO	World Health Organization
YFHS	Youth-friendly health services

Foreword

As Malawi moves into the second and final half of the implementation of the current National Strategic Plan for HIV and AIDS the country acknowledges that HIV is one of the major challenges being faced. Consequently, through the new HIV Prevention Framework the country is committed to ensuring that all necessary HIV and AIDS control measures are implemented to eliminate AIDS as a public health threat by 2030. The efforts being made by various players in HIV Prevention in Malawi have created favorable environment to achieve this aspiration. Government enacted the HIV and AIDS (Prevention and Management) Act No. 9 of 2018 to create a conducive environment to prevent and manage HIV and AIDS. This is in recognition of the fact that HIV and AIDS prevention and management is one of the key priorities that contribute to one of the enablers of the Malawi Vision 2063 (Human Capital Development).

I am pleased that, despite the adverse effects stemming from unfavorable weather conditions, COVID-19 and other economic shocks over the past recent years, Malawi has made tremendous progress towards achieving the global 95:95:95 Fast-Track targets set out in the revised NSP 2023-2027. In addition, recent estimates indicate a continued declining trend in the annual AIDS-related deaths and number of new HIV infections, particularly among adolescent girls and young women. This gives us renewed hope that, despite the existence of resource limitations, together with our implementing partners, we can speed up our efforts towards the removal of AIDS as a public health threat by 2030.

This development of the Prevention Framework took place while also revising the NSP 2020-2025 and producing the Health Sector Strategic Plan III 2023-2030 and the discovery of a novel injectable HIV preventive drug, cabotegravir. These, coupled with lessons learned from the previous implementation of the HIV and AIDS Prevention Strategy, will ensure efficient and cost-effective implementation of a well-coordinated HIV and AIDS programmes.

Mirroring on the revised NSP, this Prevention Framework emphasizes efficient utilization of available resources and implementation of targeted client-centered interventions to achieve a steep downtrend in the number of new infections and improve the survival and quality of life of People Living with HIV (PLHIV). The efforts will focus on strengthening integration and linkage of services across disease programmes within the health sector. Lessons learnt during the COVID-19 disruption of health services and the subsequent recovery should help to rebuild the national HIV and AIDS response in emergencies. This new Framework also demonstrates Government of Malawi's strong commitment towards a multi-sectoral HIV and AIDS response, led and coordinated by the National AIDS Commission (NAC), with renewed participation of all partners and stakeholders. Consequently, the HIV Prevention Strategy should be used by all stakeholders, in line with the revised NSP, as a reference for planning and implementing HIV and AIDS programmes at all levels.

Dr. Chipo Kanjo
Chairperson, NAC Board of Commissioners
December 2024

Acknowledgments

The Malawi National HIV Prevention Framework (2023 – 2027) is a product of a long and complex process of intensive consultations and negotiations, meticulous information gathering, consensus building and teamwork on specific assignments. The National AIDS Commission (NAC) is very grateful to all who contributed to the successful development of this National HIV Prevention Framework. While not everyone can be listed, the NAC specifically recognises the Joint United Nations Programme on HIV and AIDS (UNAIDS), Genesis Analytics/OPM, the German Agency for International Cooperation (GIZ) and the Clinton Health Access Initiative (CHAI) for the financial support rendered towards procurement of services of technical experts who facilitated the development of the framework and experts who did the peer-review. In addition, the NAC extends its gratitude to FHI360 for supporting the proofreading of the framework and Avenir Health for supporting the re-run of the GOALS impact model.

NAC expresses sincere gratitude to all members of the high-level National Taskforce Committee for ably steering the process of developing this framework. In particular, the leadership and support from the following: Dr Andrew Gonani, Chimwemwe Mablekisi, Rose Nyirenda, Dr Andrina Mwansambo, Dominic Gondwe, Dr Barinaadaa Afirima, Prof. Andreas Jahn and Emanuel Zenengeya. NAC further extends its gratitude to all members of thematic core groups who provided technical guidance, reference documents and feedback on the various drafts of the framework. These include: Alice Chikhoswe Mvalo, Ellious Chasukwa, James Njobvuyalema, Francis Mabedi, Bertha Sato, Anna Kutengule, Ramsey Selemani, Shadreck Sulani, Blackson Matatiyo, Mwiza Thindwa, Dr Boaz CHELUGET, Michael Eliya, Simon Sikwese, Francis Mphepo, Fatima Zulu, Dr Andrew Likaka, Dr Bridon Mbaya, Mahara Longwe, Dyson Telela, Joel Suzi, Buthelezi Mvula, Maria Ngulube, Blackson Matatiyo, Aswell Kachidowo, Dr Lawrence Chiwaula, Alvin Chidothi Phiri, Dr Ethel Lambiki, Dr David Chilongozi, Wezi Msungama, Martin Kapito, Machamo Moyo, Harrison Tembo, Dalitso Midiani, Jessie Lobeni, Linda Maliro, Lusungu Jonazi, Asharn Kossam, Jacob Phiri, Edwin Nkhata, Dr Arnold Kapachika, Mathews Chinyama and Washington Ozituosauka.

The NAC also appreciates the invaluable input from district councils through interviews and validation of the draft framework by PNHAOs, HIV programme coordinators, DACC members, implementing partners, ward councillors, traditional leaders, faith leaders, Adolescent Girls and Young Women and key populations community members.

This framework is a living document that will be subjected to mid-year revision as new data and evidence emerge. NAC will therefore rely on the commitment and dedication of partners in the national HIV and AIDS response to make these data available to enable evidence-informed refinement of the Framework.

Dr. Beatrice Matanje
Chief Executive Officer**,** National AIDS Commission
January 2025

Executive Summary

The Malawi Revised 2018–2020 HIV Prevention Strategy expired in December 2020, and NAC, in collaboration with partners, has developed a successor HIV Prevention Framework for 2023–2027. This framework will guide the national HIV prevention efforts for the next five years. The framework is aligned with the 2023–2027 Malawi National HIV and AIDS Strategic Plan (NSP) and reflects the targets called for in the Global AIDS Strategy 2021–2026 — End Inequalities. End AIDS to markedly reduce new HIV infections in the next five years, end pediatric AIDS, and eliminate all forms of HIV-related stigma and discrimination.

The HIV response appears to have reached a tipping point, transitioning from a crisis to a long-term sustained endeavour. Since 2019 the PLHIV population has been declining due to deaths from non-HIV causes among aging PLHIV and a dramatic decline in new infections due to high ART coverage. Therefore, by the end of 2023, an estimated 992,000 thousand people were living with HIV, 2% lower than the number of HIV-infected people (1,012,000) in 2019. By December 2023, a total of 943,137 HIV-positive people had been diagnosed with HIV, with 896,799 taking the life-prolonging anti-retroviral drugs (ARVs) and 852,301 had their viral load suppressed. The progress represents a 95:95:95 performance in respect to the treatment cascade targets.

Between 2010 and 2023, the number of AIDS-related deaths declined by 69% from 37,000 to 11,000. AIDS mortality has consequently declined from 252 people per 100 thousand population to 54 people per 100 thousand. New HIV infections declined by 76% from 58,000 to 14,000. HIV incidence has declined significantly in all age groups with largest reduction in children, AGYW, young men and middle-aged adults but remains high among females (20-24), and males (25-29). The progress is attributable to the strong HIV prevention efforts by HIV stakeholders. Despite Malawi's success, young men, adolescent girls, and young women continue to account for one-third of all new HIV infections. Evidence also suggests that stigma and discrimination continue to affect access to HIV services, especially among key and marginalized populations.

Socio-economic, demographic, and geographic factors are important predictors of HIV transmission in Malawi. Over 61% (572,000) of PLHIV (15+) reside in the southern region, 29% (273,500) in the central region, and 10% (95,200) in the northern region. In addition, around 58% (6,720) of all new HIV infections (15+) were registered in the southern region, 31% (3,590) in the central region, and 11% (1,270) in the northern region. Sub-regional statistics show that cities and most districts in the southern region have the highest HIV prevalence. HIV prevalence in Zomba City (14.9%), Blantyre City (13.2%), Lilongwe City (9.0%), and Mzuzu City (8.0%) is more than the national HIV prevalence (6.7%) for 15-49 years age group.

According to the 2019–2020 Biological and Behavioural Surveillance Survey (BBSS) estimates, HIV prevalence among female sex workers (FSWs) has fallen from 63% in 2013 to 49.9% in 2019 and was estimated to be five times higher than in the general population of women. In men who have sex with men (MSM) in 2019, the prevalence of 12.8% was slightly higher than in the general population of men in the sampled areas. Prisoners are another underserved and marginalised key population (KP), despite an HIV prevalence estimated at 16.3%, higher than the general population. However, it is important to point out that the Key Population groups are not mutually exclusive. For example, an unknown proportion of Transgender (TG) are also accounted under Men who have Sex with Men (MSM) and some People who Inject and Use Drugs (PWID) are also counted under MSM, FSW and TG. The KP estimates are also accounted for in the respective general population groups.

Chapter 1: Introduction

1.1 Background

The Government of Malawi (GoM) developed the revised National HIV Prevention Strategy for 2018–2020 as a tool to guide and design the implementation of evidence-based, rights-sensitive, community-centred, and targeted HIV prevention interventions. The strategy aligned with the global UNAIDS "fast-track" commitments toward ending AIDS as a public health threat by 2030, which included the reduction of new HIV infections by 75% and attaining the 90-90-90 treatment targets by the end of 2020. The strategy embraced a combination prevention approach for primary and secondary HIV prevention that was anchored in evidence-based, mutually reinforcing biomedical, behavioural, and structural interventions and targeted specific priority populations most at risk of infection and other population in geographical settings with high incidence and prevalence. Within this period, Malawi, with 24 member states, formed the Global HIV Prevention Coalition (GPC)[1] with the aim of intensifying the progress on HIV prevention in the countries with the highest numbers of new infections.

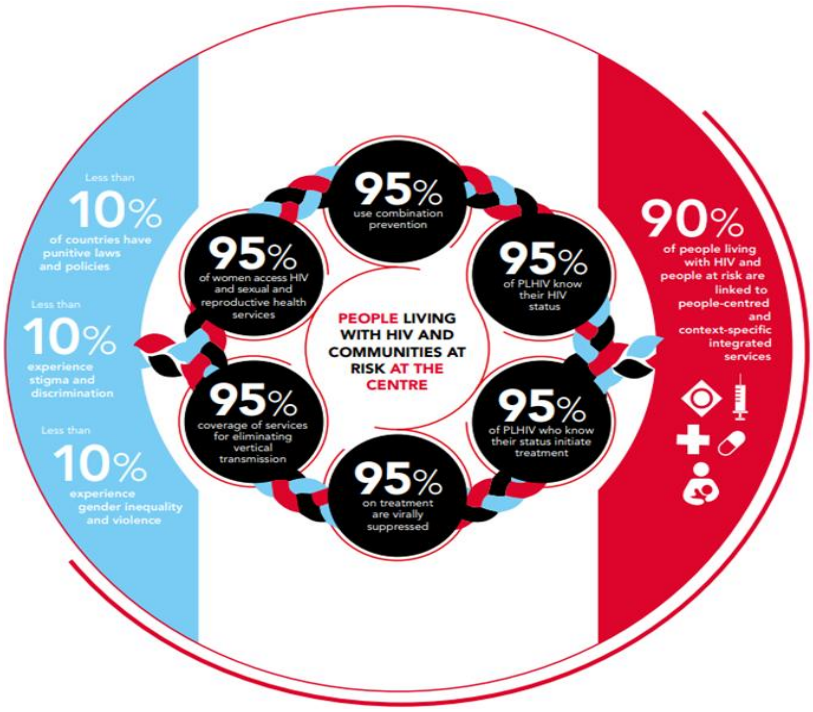


FIGURE 1: FIGURE 2 UN TARGETS FOR 2030

[1] The GPC, co-convened by UNFPA and UNAIDS, consists of the Global Prevention Working Group, the GPC Secretariat in UNAIDS, national prevention coalitions currently in 28 countries, and one regional economic community.

In June 2021, member states at the UN High-Level Meeting on HIV and AIDS recommitted to urgent action over the next five years to attain the triple 95 targets as illustrated below (Global Prevention Coalition 2021).

Furthermore, in line with the targets set out in the 2021 United Nations Political Declaration on HIV and AIDS and the 2021–26 Global AIDS Strategy, UNAIDS developed the 2025 HIV Prevention Road Map with a 10-point plan to provide guidance to all countries on how to achieve reductions in HIV incidence. The road map responds to the need for stronger action against the inequalities that hold back progress. It accounts for an evolving context that is marked by persistent inequalities and overlapping pandemics, economic challenges, shrinking space for civil society activities, and an erosion of human rights. It specified a focus on five intervention areas or "pillars":

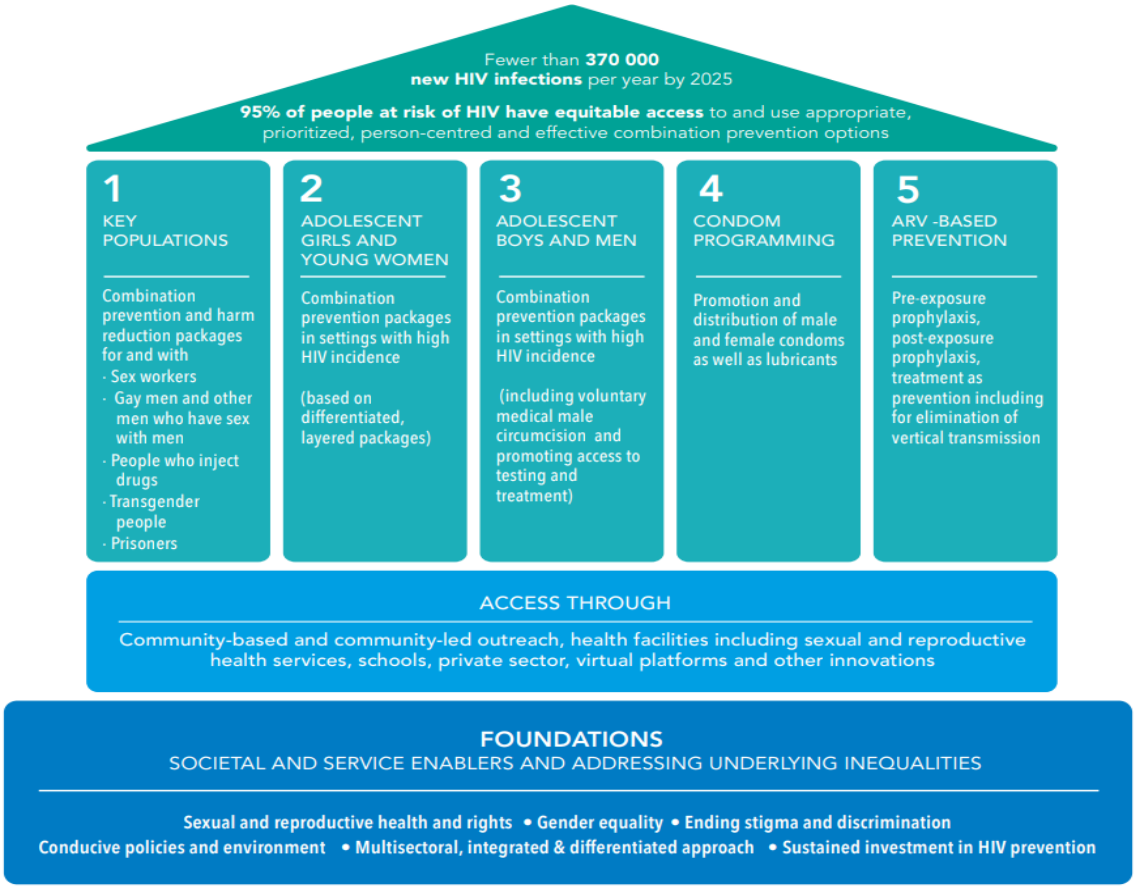


FIGURE 2: 2025 HIV PREVENTION ROAD MAP

The road map outlined steps through which each country could identify critical policy, programmatic, and structural gaps and barriers; build capacity; mobilize resources; and implement these pillars at scale. The steps prioritized practical actions founded on the principles of supporting processes that are evidence-informed, community-owned, and rights-based, as well as proven strategies that would expand coverage, include adolescents and KPs, and increase efficiency through "location-population" and people-centred approaches, including through integration with existing services and platforms.

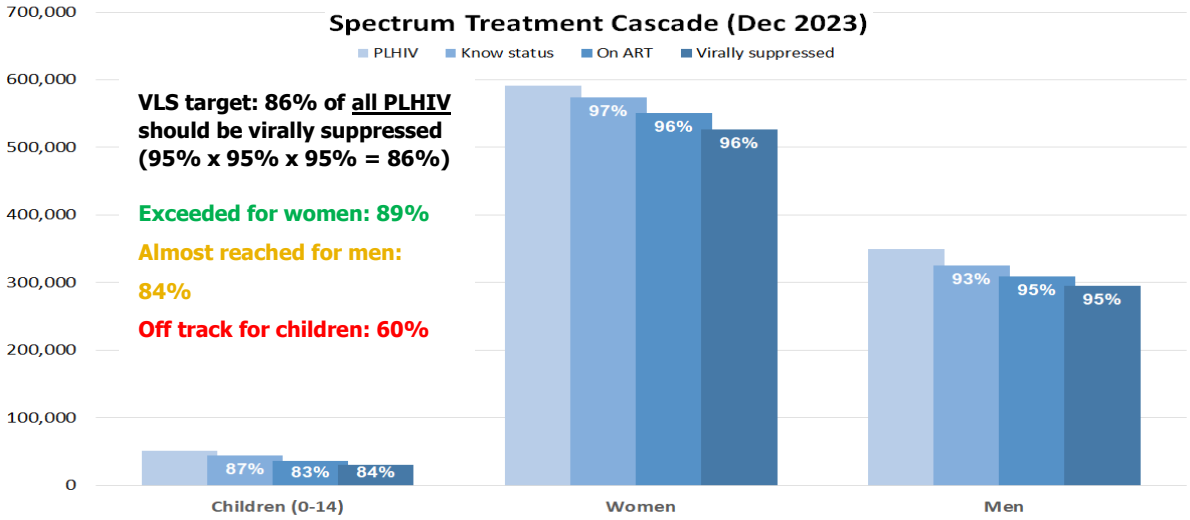


FIGURE 3: SPECTRUM CASCADE

Although Malawi is on track to achieve the 95-95-95 UNAIDS fast-track targets, there is a significant disparity in this progress by population, location, age, and gender. In addition, the country missed the 2020 HIV prevention target of a 75% reduction in new HIV infections.

This 2023–2027 National HIV Prevention Framework will serve as a pivotal guide to the Malawi HIV response in its quest to reduce new HIV infections, in line with the targets set forth by the Global Coalition on HIV Prevention. This framework complements the Malawi National HIV/AIDS Strategic Plan 2020–2025, aligned with the Global AIDS Strategy 2021–26, the HIV Prevention 2025 Road Map, and the 2021 UN political declaration on HIV. The prioritized interventions encapsulated in this framework are informed by the HIV Prevention 2025 Road Map and recent evidence from the results of the Malawi GOALS Model 2022 analysis and Malawi Population-Based HIV Impact Assessment (MPHIA) 2020–2021.

This framework aims to reduce the estimated annual number of new HIV infections from the 2022 baseline of 17,400 to 11,000 by the end of 2025 (UNAIDS n.d.[a]). This goal will be reached by implementing with fidelity the following:

i. Condom and lubricant programming
ii. Key population programming
iii. Treatment as prevention
iv. Voluntary medical male circumcision
v. Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP)
vi. Differentiated HIV testing services
vii. Elimination of mother-to-child transmission
viii. Adolescent girls and young women programming
ix. Adolescent boys and men programming
x. Sexually transmitted infection (STI), sexual and reproductive health (SRH), and gender-based violence (GBV) services
xi. Blood and blood products
xii. Social and behavioral change communications
xiii. Monitoring and evaluation

1.2 HIV Situational Analysis

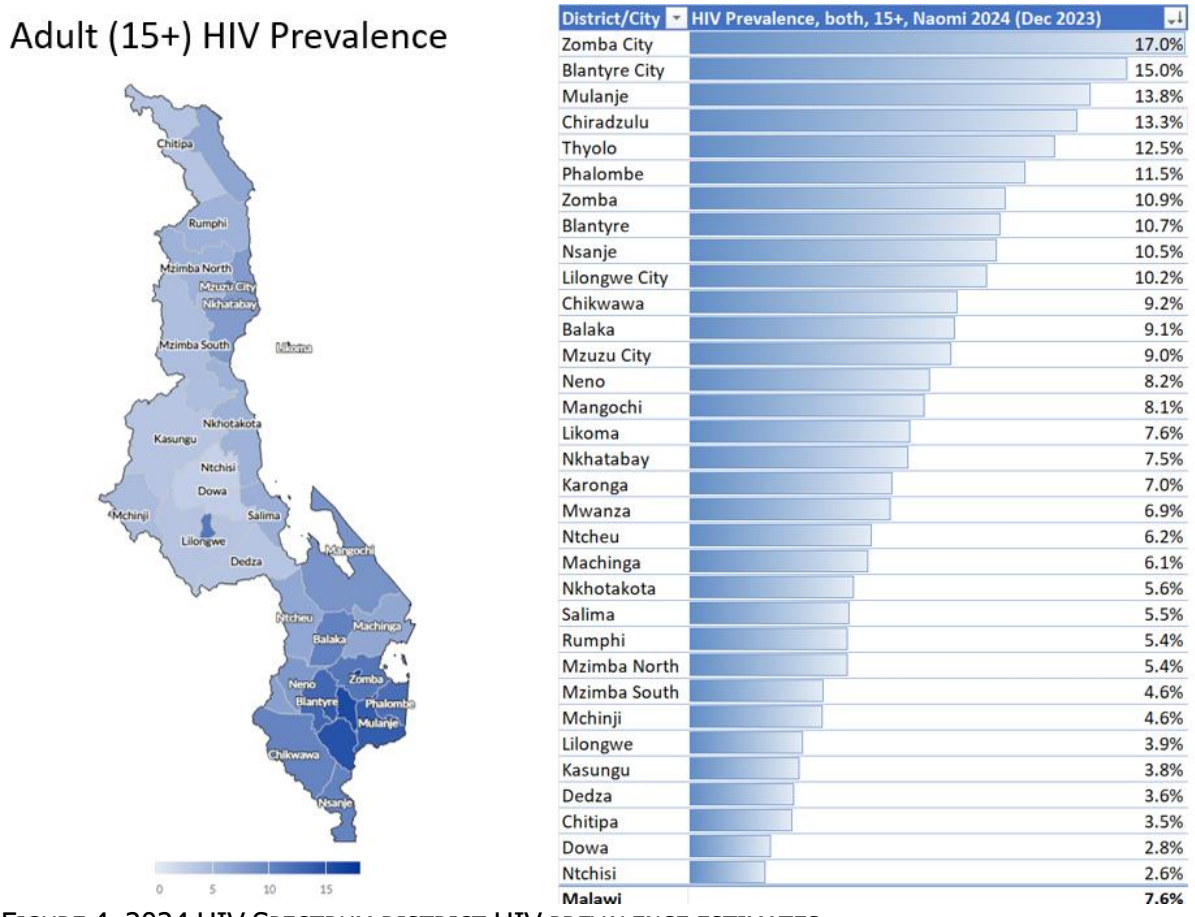
Malawi is among the countries in Southern Africa with the highest HIV burden. However, it has significantly progressed in its fight against HIV and AIDS. According to the 2024 HIV Spectrum estimate, about 992,000 people are living with HIV. Nevertheless, there has been a consistent decline in HIV prevalence, incidence, and AIDS–related deaths. Also, the annual number of new cases is 12,000 (7,400 women and 4,100 men ages 15+ and 2,300 for children 0-14 years). Despite these strides, Malawi missed the 2020 HIV prevention target of a 75% (11,000) reduction in new HIV infections and achieved a 68% reduction from the 2010 baseline.

TABLE 1. 2024 SPECTRUM/NAOMI/KP WORKBOOK ESTIMATE

Population	Age	Sex	Pop. size	PLHIV	HIV Prev.	New inf.	Incidence	AIDS deaths
General	All	All	21,162,000	991,600	4.70%	14,000	0.07%	11,300
	15+	All	12,297,000	941,000	7.70%	11,500	0.10%	9,700
		F	6,433,000	591,000	9.20%	7,400	0.13%	4,500
		M	5,864,000	350,000	6.00%	4,100	0.07%	5,200
	15-49	All	10,688,000	717,000	6.70%	11,100	0.11%	6,900
Pregnant		F	680,000	34,000	5.00%	750	0.12%	
FSW*		F	39,000	19,500	50.00%	1,500	7.69%	
MSM*		M	35,400	4,500	12.70%	150	0.49%	
TG*		All	4,900	700	14.30%	20	0.48%	
PWID*		All	8,400	2,300	27.40%	70	1.15%	
General	15-24	F	2,341,000	57,000	2.40%	3,600	0.16%	600
General	0-14	All	8,865,000	52,000	0.60%	2,300	0.03%	1,500
	<1		664,000	1,400	0.20%	1,800		400

1.2.1 HIV Prevalence, Distribution, and Trend in the General Population

The epidemiology of HIV in Malawi is informed by the MPHIA survey and the annual HIV Spectrum estimate. Over the last five years, Malawi has recorded a consistent decline in HIV prevalence. According to the 2020–2021 MPHIA reports, HIV prevalence was 8.9% among adults 15 and older, which implies that about nine out of every 100 adults in Malawi are living with HIV. The 2024 HIV Spectrum estimate puts the prevalence at 7.7% among adults 15+, with a higher prevalence among women (9.2%) than men (6.0%). There is marked variation in the prevalence according to demographic factors and geographical location. For instance, the 2024 UNAIDS Naomi model demonstrates regional variations. HIV prevalence (15-49) in the Southern region (9.5%) is almost twice as high as in the Northern (5.2%) and Central (4.5%) regions.



District/City	HIV Prevalence, both, 15+, Naomi 2024 (Dec 2023)
Zomba City	17.0%
Blantyre City	15.0%
Mulanje	13.8%
Chiradzulu	13.3%
Thyolo	12.5%
Phalombe	11.5%
Zomba	10.9%
Blantyre	10.7%
Nsanje	10.5%
Lilongwe City	10.2%
Chikwawa	9.2%
Balaka	9.1%
Mzuzu City	9.0%
Neno	8.2%
Mangochi	8.1%
Likoma	7.6%
Nkhatabay	7.5%
Karonga	7.0%
Mwanza	6.9%
Ntcheu	6.2%
Machinga	6.1%
Nkhotakota	5.6%
Salima	5.5%
Rumphi	5.4%
Mzimba North	5.4%
Mzimba South	4.6%
Mchinji	4.6%
Lilongwe	3.9%
Kasungu	3.8%
Dedza	3.6%
Chitipa	3.5%
Dowa	2.8%
Ntchisi	2.6%
Malawi	**7.6%**

FIGURE 4. 2024 HIV SPECTRUM DISTRICT HIV PREVALENCE ESTIMATES

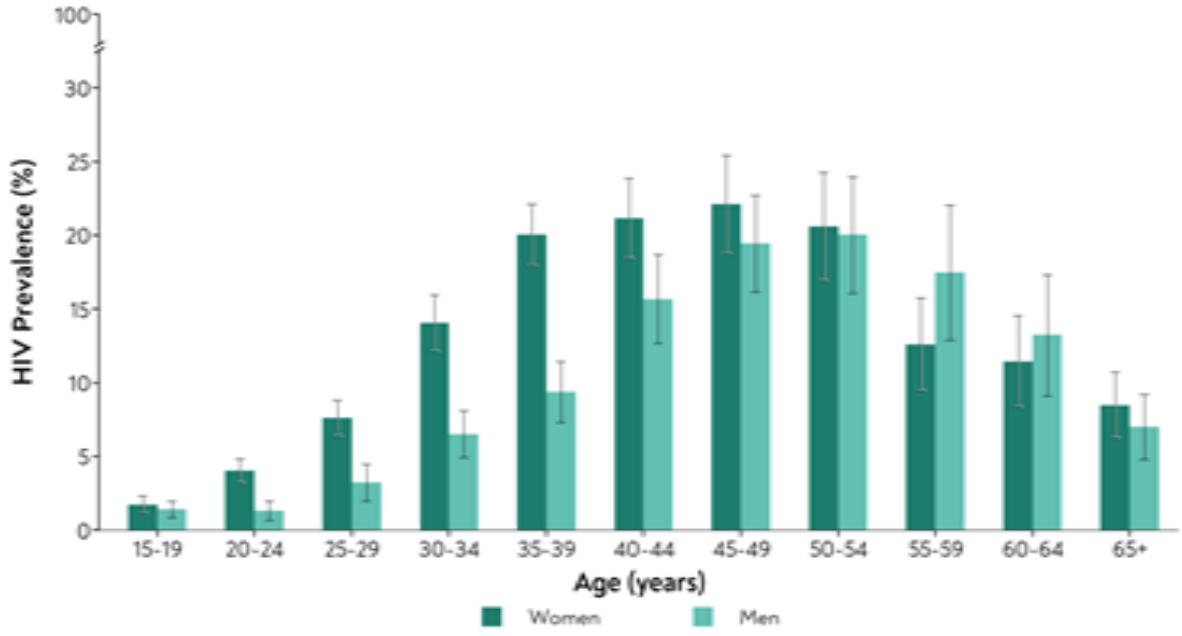
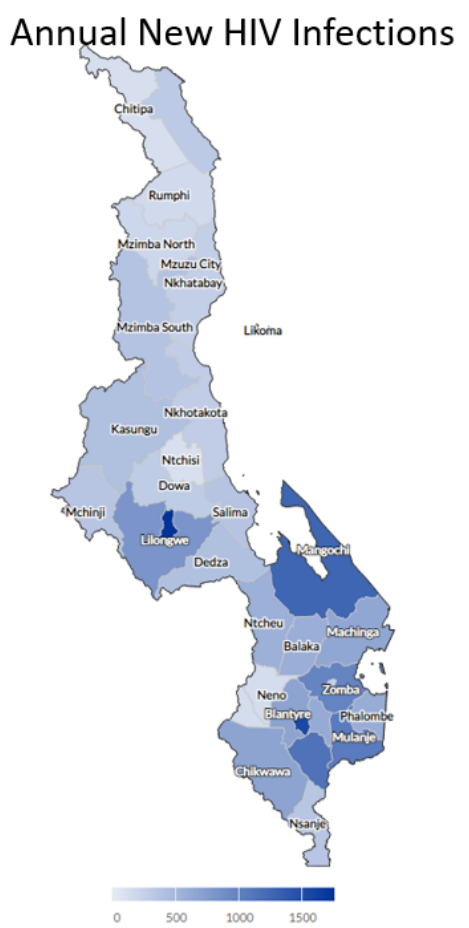


FIGURE 5. HIV PREVALENCE BY AGE AND SEX, MPHIA 2020–21

1.2.2 HIV Incidence in the General Population

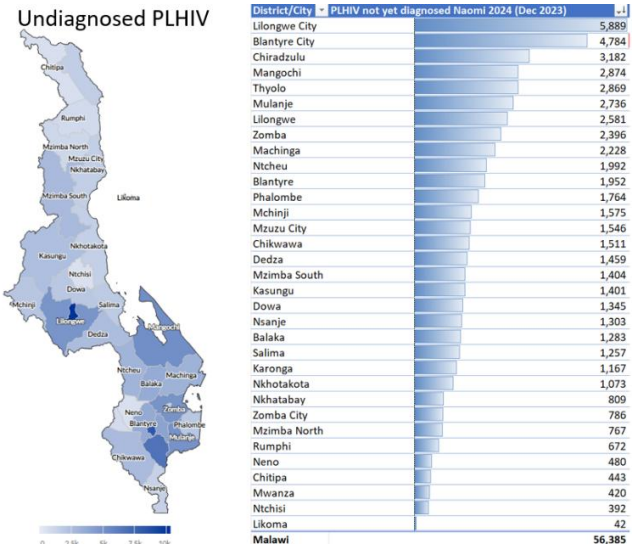
According to MPHIA 2020–2021, the annual HIV incidence was 0.21%, corresponding to 20,000 new cases annually. There is a considerable decline in the estimated incidence reported by the 2020–2021 MPHIA and the 2024 HIV Spectrum estimate. According to the HIV Spectrum estimate, between 2018 and 2023, the annual HIV incidence among adults (15–49 years) declined by 54% (0.24% to 0.11%), with about 11,100 new infections annually. Incidence has declined faster in men and remains considerably higher in women (0.14%) than in men (0.08%). Instructively, there were significant variations in the incidence by population and geographic location. As depicted in Figure 6, most new infections occur in the southern part of the country. Six districts — Lilongwe City, Blantyre City, Mangochi, Mulanje, Zomba and Thyolo — accounted for over 50% of all new infections in 2023, while over half of all districts (24) had fewer than 500 new infections that year.



District/City	Annual new infections Naomi 2024 (Dec 2023)
Lilongwe City	1,281
Blantyre City	1,213
Mangochi	1,010
Mulanje	913
Zomba	765
Thyolo	737
Lilongwe	695
Chikwawa	521
Blantyre	517
Machinga	488
Phalombe	483
Chiradzulu	457
Ntcheu	436
Balaka	397
Kasungu	327
Dedza	322
Mchinji	309
Mzimba South	301
Nsanje	300
Mzuzu City	298
Salima	284
Karonga	268
Dowa	246
Nkhatabay	221
Nkhotakota	217
Zomba City	185
Mzimba North	159
Rumphi	132
Neno	111
Mwanza	99
Ntchisi	85
Chitipa	85
Likoma	12
Malawi	**13,875**

FIGURE 6. HIV NEW INFECTIONS BY DISTRICT

In addition, about 50% of undiagnosed PLHIV reside in Blantyre City, Lilongwe city, Chiradzulu, Mangochi, Thyolo, Mulanje and Lilongwe. While there are variations in undiagnosed by population, with other men contributing 41%, there are higher numbers of new cases in women than in men. Out of the estimated 14,000 new infections in 2023, 16% (2,290) were children infections due to mother-to-child transmission), 28% (3,900) were men, and 61% (8,600) were women, of which AGYW (15-24) accounted for 42%(3,600).



District/City	PLHIV not yet diagnosed Naomi 2024 (Dec 2023)
Lilongwe City	5,889
Blantyre City	4,784
Chiradzulu	3,182
Mangochi	2,874
Thyolo	2,869
Mulanje	2,736
Lilongwe	2,581
Zomba	2,396
Machinga	2,228
Ntcheu	1,992
Blantyre	1,952
Phalombe	1,764
Mchinji	1,575
Mzuzu City	1,546
Chikwawa	1,511
Dedza	1,459
Mzimba South	1,404
Kasungu	1,401
Dowa	1,345
Nsanje	1,303
Balaka	1,283
Salima	1,257
Karonga	1,167
Nkhotakota	1,073
Nkhatabay	809
Zomba City	786
Mzimba North	767
Rumphi	672
Neno	480
Chitipa	443
Mwanza	420
Ntchisi	392
Likoma	42
Malawi	**56,385**

FIGURE 7. DISTRIBUTION OF UNDIAGNOSED PLHIV BY LOCATION

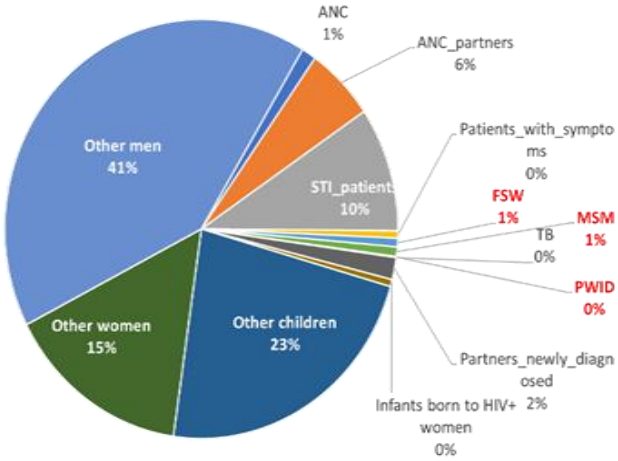


FIGURE 8. DISTRIBUTION OF UNDIAGNOSED PLHIV BY POPULATION

According to the UNAIDS classification, Malawi, with an HIV incidence of 0.7%, is considered a low incidence setting. Although key populations constitute a smaller proportion of society, the incidence among key populations ranges from 0.48% to 7.7%, which is at least four times higher than the national incidence.

1.2.3 HIV-related Mortality

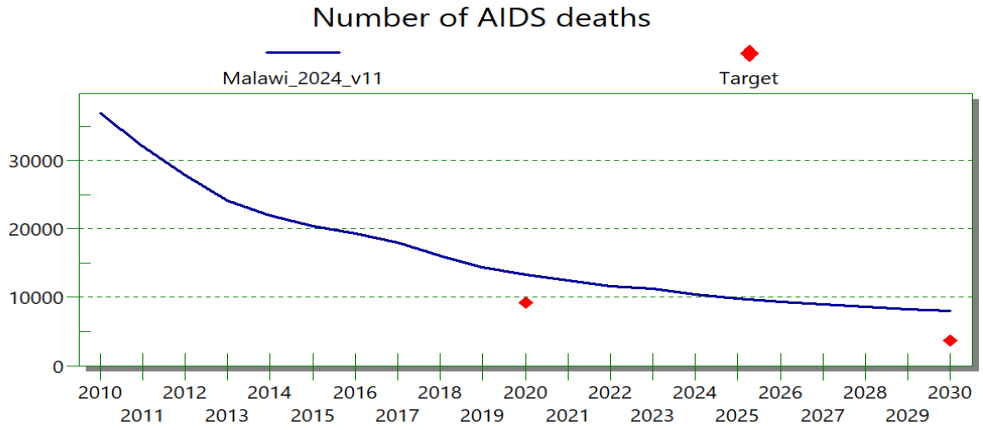
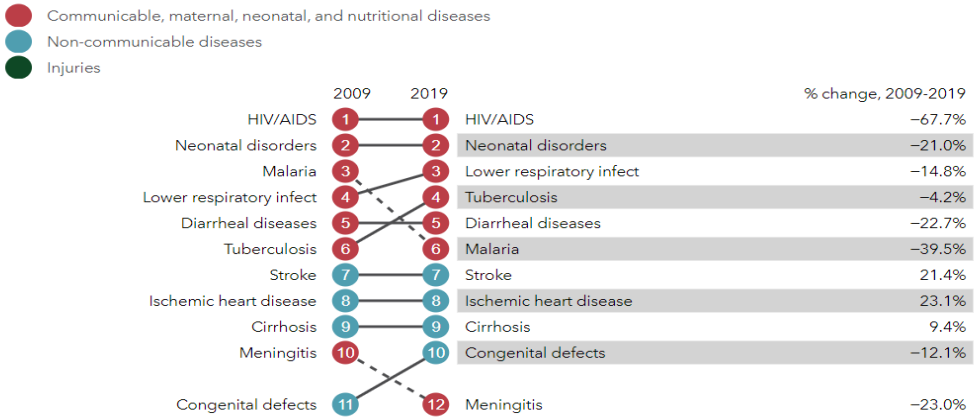


FIGURE 9: TRENDS IN AIDS MORTALITY

According to the Institute of Metric and Evaluation, HIV/AIDS is the leading cause of death in Malawi. However, from 2009 to 2019, AIDS-related deaths declined by 67.7% (Figure 9) (Institute for Health Metrics and Evaluation 2023). Similarly, evidence from the 2024 HIV Spectrum estimates show a 69% decline in AIDS-related deaths — from 37,000 in 2010 to 11,000 in 2023.

FIGURE 10. CAUSES OF ALL DEATHS IN 2009–2019 FOR ALL AGES

GBD 2019 DISEASES AND INJURIES COLLABORATORS 2020)



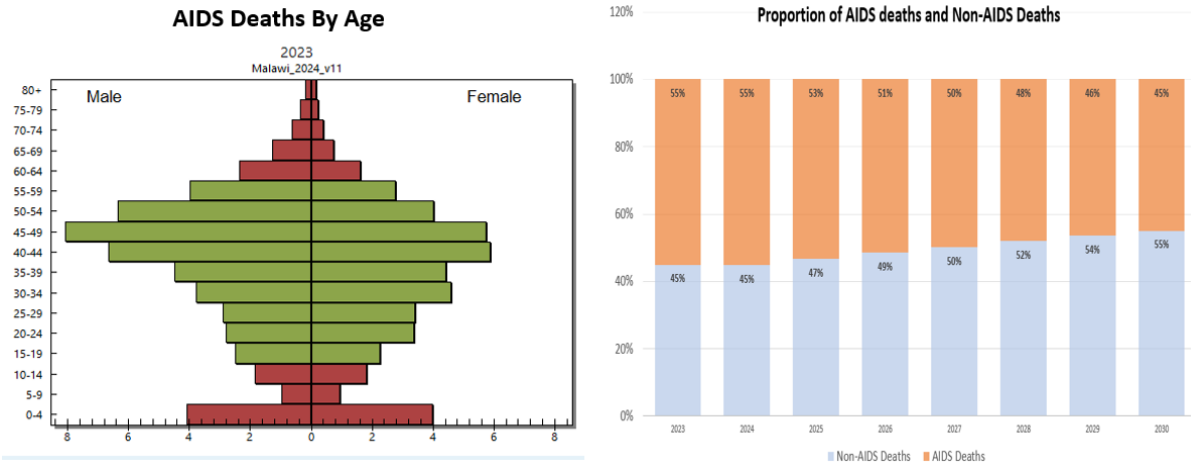


FIGURE 11. AIDS-RELATED MORTALITY

1.2.4. HIV Among Key and Vulnerable Populations

In line with global best practices, Malawi recognizes sex workers, MSM, transgender people, people who inject drugs (PWID), and prisoners as KPs at an increased risk of acquiring and transmitting HIV infection due to specific higher-risk behaviours and as important to the dynamics of HIV programming. While clients of female sex workers (CFSWs), migrant labourers, people displaced due to emergencies, uniformed personnel, AGYW, and persons with disabilities are considered vulnerable populations. According to the 2019–2020 Malawi BBSS, there are about 36,100 FSWs and 23,200 MSM nationally, with the majority in the Central and Southern regions. However, considering that the size estimation for MSM is lower than the global median (which suggests that 1% of the male population is MSM), this is likely

an underestimate of the actual population of adult MSM in Malawi (WHO 2020). Size estimation data on male sex workers (MSWs) and PWID in Malawi are lacking. Preliminary results from a formative study on trans people conducted by NAC estimated that 10 out of every 100,000 adults in Malawi might be trans (National AIDS Commission 2021). The study further revealed that most trans people in Malawi engage in anal sex, which increases their risk of HIV acquisition.

Like in most countries within sub-Sahara Africa, KP in Malawi face a disproportionate burden of HIV and STIs driven by structural barriers such as stigma and discrimination, violence, human rights violations, poverty, and limited access to KP-friendly services (National AIDS Commission 2021). A review of available country data shows a drop in HIV prevalence among FSWs (from 62.7% to 49.9%) and MSM (from 21.4% to 12.8%) in the past 10 years, but a 49.9% prevalence in FSWs and 12.8% in MSM is still unacceptably high (Government of Malawi, National AIDS Commission 2020).[2] HIV burden among KPs varies by district.

People in closed settings such as prisons have limited access to high-impact prevention services due to factors such as policy limitations. For example, some HIV prevention services are not offered in prisons such as condoms and lubricants due to the prohibition of same-sex sexual activities. Also, there are delays in referral to care and treatment for severe illnesses, including tuberculosis (TB), and poor adherence to ART among HIV-positive prisoners (Gondwe et al. 2021).

This strategy recognizes that prioritising these populations is essential to breaking the dynamics of an HIV transmission network between low-risk and high-risk populations.

1.2.5. Adolescent Girls and Young Women

Young people, especially AGYW, are highly vulnerable to HIV infection compared to older people. Although there has been a significant decline in HIV incidence in Malawi, AGYW still contribute a significant proportion of the new infections. According to the Malawi 2024 Spectrum estimates, AGYW, who constitute only 11% (2,340,852) of the entire population (21,162,038), contribute up to 26% (3,591) of all new HIV infections (14,000); However, HIV incidence remains low (<0.2%) among 15–24-year-old females in all districts in 2023. Interestingly, the 2024 Malawi HIV estimates show that incidence in the age group 25–29 exceeds incidence in 20–24-year-old women, and it is about three-fold higher than in 15–19-year-old girls and women. Therefore, Malawi has redefined the age band for AGYW programming to 10–29 years. Furthermore, the incidence among AGYW (20–24) is about four times that of their male peers. Evidence shows a correlation between the HIV incidence among AGYW and men ages 30–44. According to MPHIA 2021, in Malawi, nine out of 100 people ages 15 and older are living with HIV, and prevalence is higher among females than males. The gender disparity is largest amongst youth 15–24, where the prevalence among females (2.8%) is twice that of their male (1.4%) counterparts.

[2] These two data points are from the 2014 DHS and the 2019 IBBS and so may not be strictly comparable.

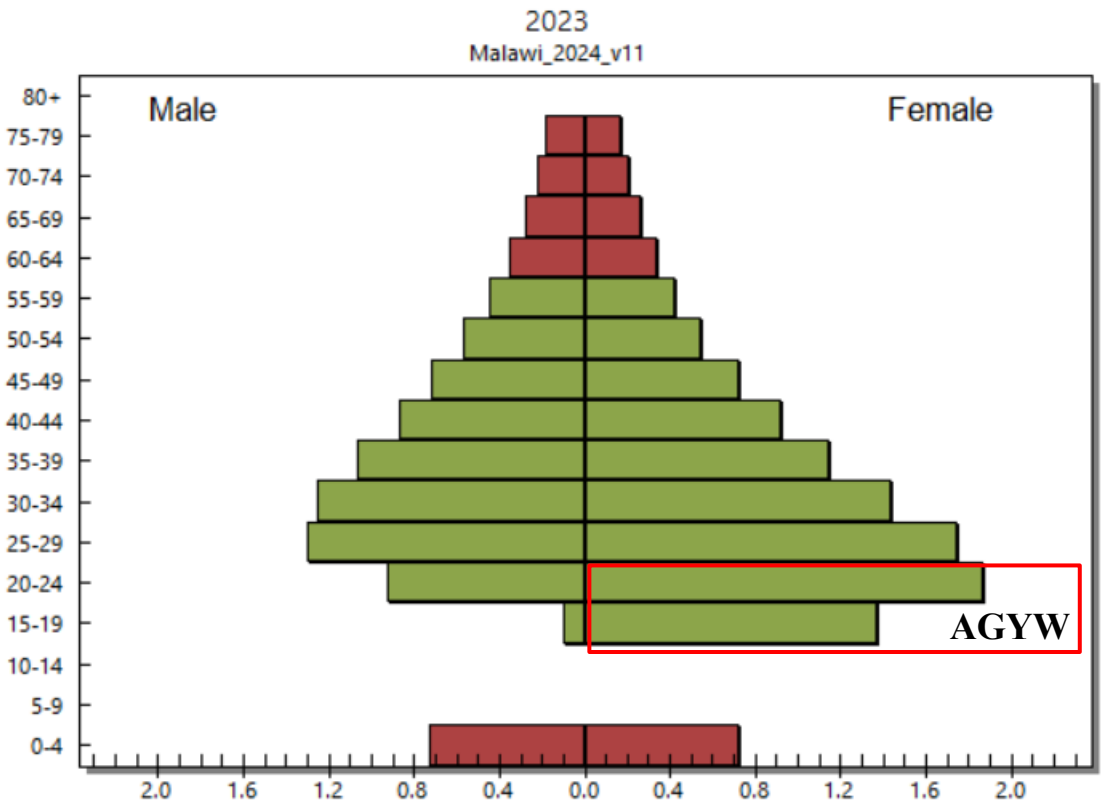


FIGURE 12. HIV INCIDENCE DISTRIBUTION

Factors associated with vulnerability among AGYW are multifactorial. Young people, especially young females, lack comprehensive knowledge about HIV. Young women lack adequate SRH information; are not empowered to communicate with peers, potential sex partners, and adults regarding their needs; and often do not realize they are at risk.

1.2.6. Elimination of Mother-to-Child Transmission

The country aspires to triple elimination of mother-to-child transmission (EMTCT) of HIV, congenital syphilis, and viral hepatitis. According to the 2023 spectrum estimate, antenatal care (ANC) attendants were at an all-time high in 2022, and there was a steep decline in HIV prevalence among pregnant women (5.2%); nevertheless, the HIV status ascertainment dropped to <98%, with the proportion of known positives levelling off around 77%, while syphilis testing was at 72%. Mother-to-child transmission is estimated at 2.1% at six weeks and 6.5% at the end of the breastfeeding period. There was slightly lower prevention of mother-to-child transmission (PMTCT) coverage long term, with resultant accumulation of child infections. However, there was a marked reduction in paediatric infections from the 2010 baseline of 15,000 to 2,500 in 2022. Nevertheless, there was a significant decline in paediatric ART coverage (12% lower in 2022 compared to 2010). Testing among exposed infants remained suboptimal at 75%, 69%, and 65% at two, 12, and 24 months, respectively, in 2021, against the national targets of 85%. Nevertheless, this increased from overall early infant diagnosis (EID) coverage of 15% in 2015. There is potential to achieve the targets as

seen in some districts including Mchinji, Mzimba North, Phalombe, and Neno, where performance has consistently been above the national targets. The availability of point-of-care (POC) machines in these districts has greatly increased the uptake of EID services.

Despite the progress in the eMTCT of HIV, some challenges remain. These include low levels of retention of mothers and children on ART; suboptimal syphilis screening among pregnant women; low EID coverage; more than 50% of new paediatric HIV infections occurring during the breastfeeding period from women who are seroconverting, most likely newly infected from their spouses; and interruption in treatment among women already on ART

1.2.7. Adolescent Boys and Men

Adolescent boys and men have distinct health needs and vulnerabilities and engaging them can benefit everyone — especially other vulnerable populations such as AGYW and breastfeeding mothers. Low rates of male testing and treatment increase HIV transmission and affect their partners, families, and communities. Men's low utilization of services is not just the consequence of individual behaviour but is also related to structural factors that limit the adequate provision of services.

Multifaceted tailored interventions that address adolescent boys' and men's needs, aspirations, and preferences are required. These interventions put men at the center of services. This necessitates planning and implementing client-centred strategies that fit clients' lives and providing services that are easy to access. Rationale and Justification

This framework is developed in line with GoM desire to streamline and harmonize relevant strategic documents. Furthermore, findings from the evaluation report of the HIV prevention strategy 2018–2020 and other recent emerging issues informed the development of this framework.

1.2.8. Framework Overview

The goals and objectives of the HIV Prevention Framework 2023–2027 align with the extended NSP 2022–2027, Global AIDS Strategy 2021–2026, and the HIV Prevention 2025 Road Map. The HIV Prevention Framework (2023–2027) aims to accelerate the projected decline in new infections during 2023–2027 to meet the 2030 UNAIDS target of a 90% reduction from the 2010 baseline. This requires a 22% acceleration from the projected trend under the status quo (Figure 13).

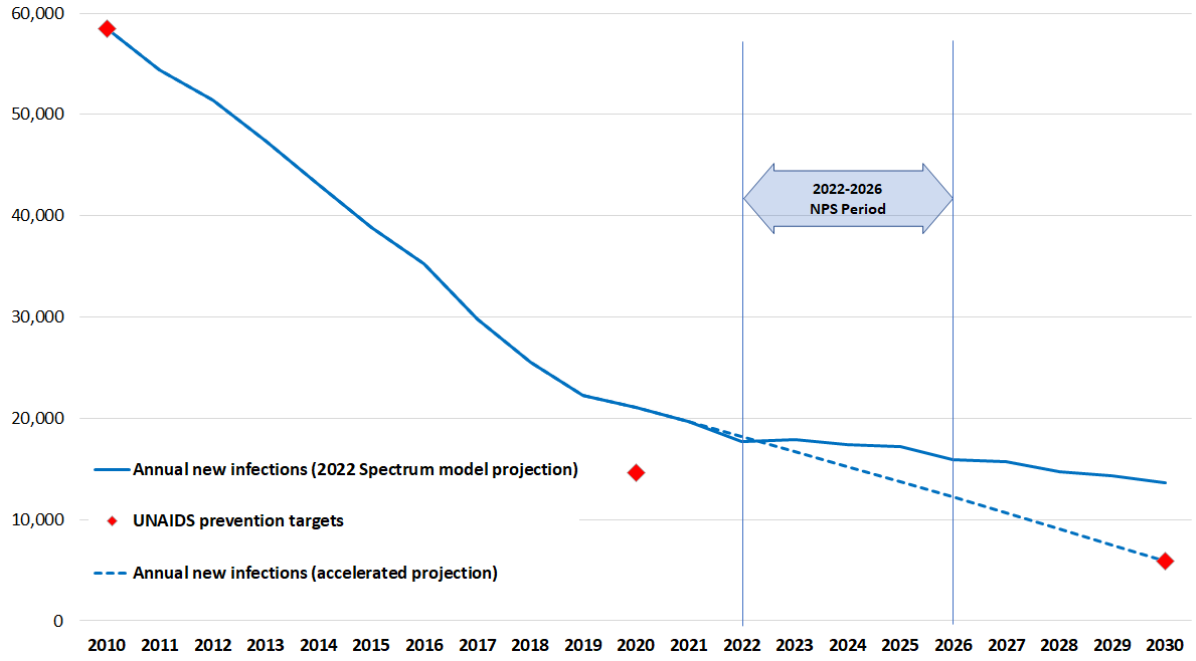


FIGURE 13. PROJECTED DECLINE IN ANNUAL NEW HIV INFECTIONS UNDER THE STATUS QUO VS. WITH THE INTENDED ACCELERATION TO REACH THE 2030 UNAIDS TARGET

The framework aims to reduce new infections to less than 11,000 by scaling up with fidelity tailored, high-impact HIV prevention interventions for targeted populations and high incidence geographic locations.

The framework will use a "prevention cascade" approach to conceptualize HIV prevention as more than a series of interventions and provide a functional basis for strengthening the delivery of prevention services (UNAIDS 2021). The cascade approach will use existing evidence to demonstrate successes and gaps in HIV prevention programming. The prevention cascade highlights the core functions needed for effective HIV prevention services, which are (1) targeting, (2) demand generation, (3) quality delivery, and (4) sustained use/structural issues at a national level (UNAIDS 2021).

1.2.9. Evaluation of the 2018–2020 HIV Prevention Strategy: Achievements and Gaps

The 2018–2020 Revised HIV Prevention Framework evaluation demonstrated that while many advances had been made, with several targets achieved or surpassed, some significant gaps remained that, if not addressed, will prevent Malawi from reaching the global 2025 HIV prevention and the 2030 HIV elimination goals. These achievements and gaps are detailed in the Evaluation Report but can be summarized as follows:

TABLE 2. SUMMARY OF EVALUATION REPORT

Interventions/ Domain	Findings
Condoms and lubricant programming	• Limited access and uptake of condoms. • Significant gaps in SBCC for condoms.
Voluntary medical male circumcision (VMMC)	• Low coverage of VMMC services in the high HIV burden districts and other districts.
AGYW	• Significant gains have been made in rights and services targeting AGYW. • Increase multisectoral coordination mechanism with consensus on a minimum package of services for AGYW and delivery strategies • Improved engagement and leadership of AGYW through youth-led community-based organizations (CBOs). • Limited skill and capacity to delivery youth-friendly health services (YFHS) in health facilities • Poor mobilization at community level
Key and vulnerable populations	• Investment in KP programming is predominantly donor driven with limited investment from government. • Availability of relevant national policy documents for KP • Existing national technical working group (TWG) • Proper engagement of KP-led organization in projects funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) • Existence of social and structural barriers such as discriminatory laws and policies • Absence of KP-tailored SBCC materials
eMTCT	• High testing coverage • Low EID follow-up and retention at 6 and 12 months • Index testing is suboptimal. • High level of MTCT during breastfeeding period
PrEP	• Rolled out in 2020 • Limited number of trained PrEP providers • Community and event-driven PrEP yet to be rolled out
STIs	• Good HTS-STI integration • Increasing antimicrobial-Neisseria gonorrhoea resistance among STI clients • Frequent stock-outs of STI medicines and laboratory reagents especially in private health facilities.
HIV testing services (HTS)	• Increased uptake of HTS after the introduction of universal testing • Decline in conventional testing due to policy shift — prioritization of testing efficiency • Increased testing uptake among KP due to adoption of innovative testing modalities such as HIV self-testing (HIVST) • Poor linkage to services among beneficiaries of community-based services

Blood and blood product safety	• Schools and community events are major source of blood donation. However, their closure during the COVID-19 pandemic significantly affected blood donation.
Social and behaviour change communication (SBCC)	Fragmented implementation of SBCC strategies
Monitoring and evaluation (M&E) and strategic information	Significant investment in data management systems
Resource gap analysis	Significant funding gaps (US$20.94 million) across all strategic objectives
Leadership and governance	• Strong political leadership and commitment at all levels, as seen through the formulation and enactment of several HIV and AIDS policies, guidelines, and commitments. • Coordination challenges: o A decline in financial resources has resulted in the downsizing of coordinating structure operations. o Parallel coordinating mechanisms o Duplication of activities due to weak coordination and program mapping
The impact of the COVID-19 pandemic on HIV prevention	• The pandemic affected the delivery of all HIV services; however, the prevention services were mostly affected due to de-prioritization of community HIV interventions.

1.2.10. Theory of Change

Recognizing the complexity of the multilevel factors driving HIV infections, the framework adopts a multilevel and multisectoral approach that holistically adopts the theory of change. It is theorized that the HIV prevention gains will be realized through a set of prioritized interventions focusing on the implementation of data-driven, person-centred HIV combination prevention packages combined with structural interventions — stakeholder engagement and collaborations; private-public sector partnerships; community engagement; capacity building; health systems strengthening; strengthened research, strategic information, and monitoring; and leadership and governance — supported by adequate financing and an enabling legal environment.

The theory of change (ToC) presented in Figure 14 helps communicate the role of the current HIV Prevention Framework (2023–2027) and subsequent interventions in the context of broader change processes. This ToC plays a critical role in informing both the results framework presented in Table 2 and the M&E plan (Annex 2), which will measure the progress,

results, and effectiveness of the strategy and subsequent interventions.

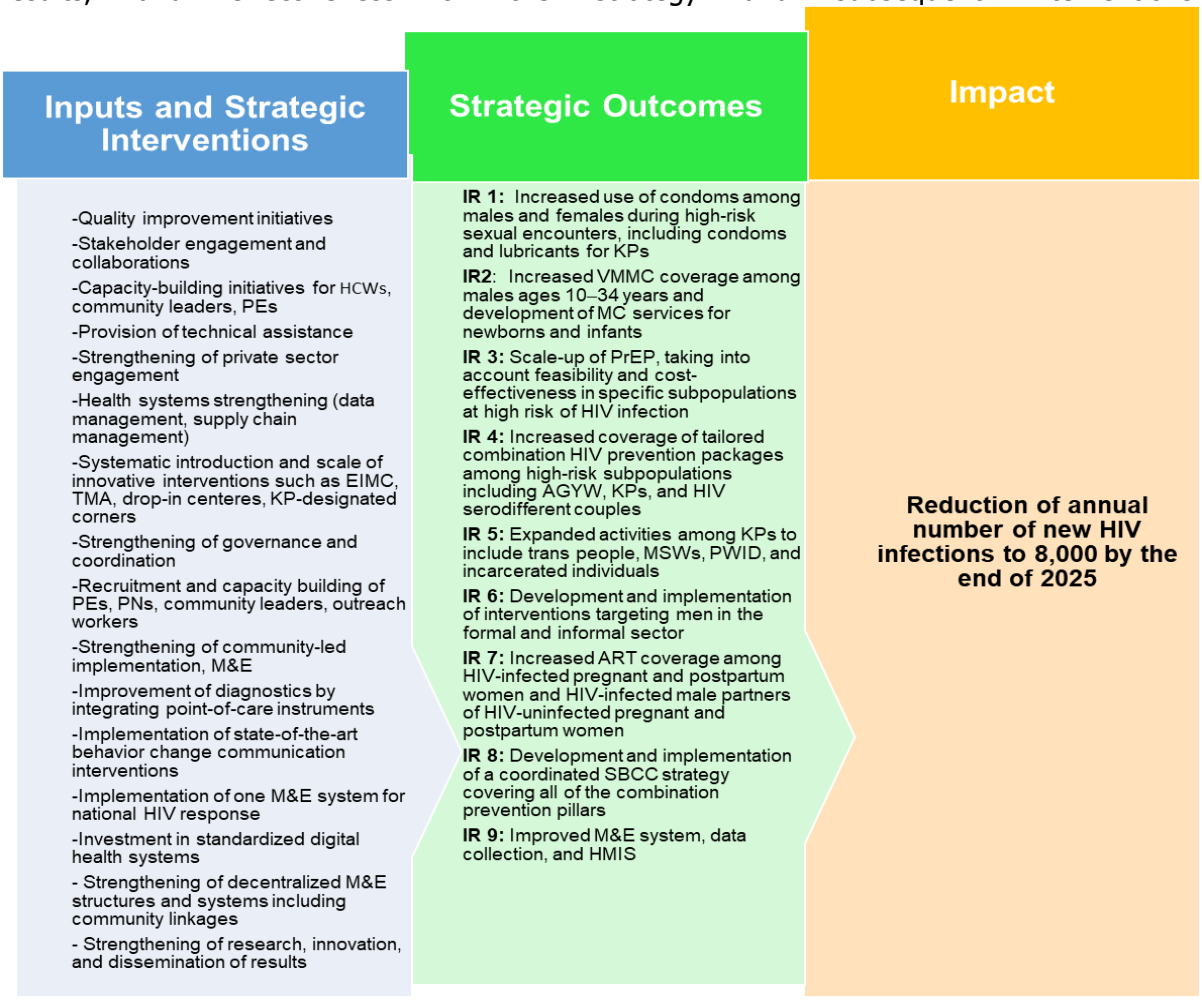


FIGURE 14. THEORY OF CHANGE FOR THE MALAWI HIV PREVENTION FRAMEWORK (2023–2027)

Chapter 2: Guiding Principles

The strategy shall be anchored on the following guiding principles:

2.1. Public Health Approach

This framework recognizes the need to maximize impact by prioritizing evidence-based, cost-efficient interventions, strengthening health systems to enable high-quality service delivery, and integrating services to deliver combination prevention services.

2.2. Right To Health and Rights-Based Programming

This framework will prioritize equitable delivery of rights-based, gender-responsive, and people-centred interventions for all targeted populations, including key and vulnerable populations. It shall promote the right to equitable health services, including access to adequate HIV prevention, treatment, care, and support, and SRH services. Services shall be offered in a stigma free environment using a differentiated service delivery mechanism including through a community platform with the aim of taking services closer to the most at-risk population. Stigma and discrimination constitute significant barriers to implementing the national response to the HIV and AIDS epidemic. The framework encompasses the protection and promotion of human rights among PLHIV and KPs in the prevention of HIV transmission, and mitigation of the social and economic impacts of the pandemic.

2.3. Integrated Service Delivery

To improve efficiency and health outcomes, this framework promotes integrated health service delivery, integrating HIV with TB, sexual and reproductive health and rights (SRHR), noncommunicable diseases, viral hepatitis, mental health, and nutrition. Effective coordination and integration are essential for the management of co-infections. Guidelines need to be strengthened to assist in service integration (e.g., SRH/HIV integration).

2.4. Investment Approach and Sustainability Plan

The investment framework recommended by UNAIDS prioritizes the design and implementation of HIV interventions that (1) significantly reduce HIV risk, transmission, morbidity, and mortality; (2) promote community engagement and synergies with the broader development work; and (3) ensure the rational allocation of resources in line with the country's epidemiology and context.

2.5. Evidence-Based Programming for High-Quality, High-Impact Interventions

The Malawi HIV response has a legacy of being guided by science and data to drive programming decisions for greater effectiveness and efficiency. This framework will prioritize investment in evidence that aims to transform the future of HIV prevention.

This framework will build upon the evidence to prioritize investment in high impact interventions and sustained high quality to ensure that 2025 targets are achieved and effectively contribute toward ending AIDS by 2030. The framework suggests concerted efforts to improve the coverage of HIV services, complemented by efforts to ensure that these services are of very high quality and are delivered in line with national and international standards, as well as evidence of what works in the Malawi context.

2.6. Multisectoral Engagement and Effective Partnerships

Reinforce and deepen strategic alignment and partnership with other government agencies and ministries including development partners and civil society organisations. Elevate and strengthen the role of district health systems, communities, and civil society organisations in the HIV/AIDS response through strategic partnerships.

2.7. Community Involvement and Leadership

This framework will prioritize putting the community at the centre and promote meaningful community engagement and leadership including community-led monitoring. Malawi will continue to fully engage the unique assets, capacities, and comparative advantage of communities, including key populations-led, youth-led, and women-led organizations, faith-based organizations, and PLHIV, to drive meaningful, people-centred impact through sustained community leadership.

2.8. Gender Mainstreaming

This framework acknowledges that women and girls are disproportionately affected by the HIV and AIDS epidemic. It also recognizes that gender is a key driver of HIV that affects the HIV cascade of prevention, testing, treatment, care, and support. The strategy promotes comprehensive sexuality, gender-transformative and affirming interventions, and working with women and girls, men and boys, other genders, and KPs. Gender power dynamics are a key driver for decision-making regarding the use of condoms, safe-sex relationships, and access to health care.

2.9. Diversity, Equity, and Inclusion

Ensure that the most vulnerable and underrepresented communities are effectively positioned and capacitated to lead discussions and decisions shaping the critical aspects of prevention and treatment programs that affect their communities.

The HIV Prevention Framework (2023–2027) acknowledges, respects, and reflects the diversity of experience, sexual orientation, sexual expression, gender identity, and occupational choices. It recognizes and is committed to upholding every person's right to equality, equity, dignity, and freedom from stigma and violence. Every effort has been made

to ensure substantive and meaningful engagement of KPs, AGYW, and recipients of care in developing this national HIV Prevention Framework (2023–2027).

Chapter 3: Strategic Goals, Objectives, and Priority Areas

3.1. Goal

The HIV Prevention Framework (2023–2027) aims to reduce the annual number of new HIV infections from a baseline of 17,400 in 2022 to 8,000 by the end of 2027. The goal will be realized by achieving the following objectives:

3.2. Strategic Objectives

i. Increase access to, uptake of, and coverage of high-quality HIV combination prevention interventions targeting high-risk, key, and priority populations in all high incidence districts.
ii. Reduce mother-to-child transmission of HIV, congenital syphilis, and hepatitis B in pregnant and breastfeeding women.
iii. Mitigate structural and policy barriers that exacerbate HIV risk and vulnerability.
iv. Increase social acceptance and demand for HIV combination prevention interventions among high-risk, key, and priority populations.
v. Strengthen leadership, governance, and coordination for HIV prevention at national and sub-national levels.
vi. Strengthen health systems for HIV combination prevention at all levels of service delivery.

3.3. Priority Areas

This framework has priority areas that consolidate aspirations contained in the strategic objectives. The priority areas are:

i. Condom and lubricant programming
ii. Treatment as prevention
iii. EMTCT
iv. Adolescent girls and young women
v. Adolescent boys and men
vi. Sexually transmitted infections
vii. Blood and blood product safety
viii. Voluntary medical male circumcision
ix. Key and vulnerable populations
x. HIV testing services
xi. Pre-exposure prophylaxis and post-exposure prophylaxis
xii. SBCC
xiii. Monitoring and evaluation

Priority Area 1: Condom and Lubricant Programming

Condoms are the only intervention that protects against STIs, including HIV, and pregnancy. In Malawi, condoms are distributed freely through public and private sector service delivery points at facility and community level. A review of condom program data shows that 68% of condom distribution in Malawi is through the public sector, with 61% through health facilities, and only 7% of the public sector condom distribution is through community structures. During the implementation of this framework, Malawi will expand the Total Market Approach which entails to distribute the public, socially marketed, and commercially marketed condoms.

Objective 1: To increase access, uptake, and quality of both male and female condoms and lubricants among high-risk populations, focusing on high HIV-prevalence geographical areas of the country using the Total Market Approach.

Strategic interventions

- Promote innovative approaches to distribute condoms and lubricants to the last mile.
- Increase access to and uptake of both male and female condoms and lubricants among high-risk populations, focusing on geographical areas with high HIV prevalence.
- Establish or use formal and informal community structures within and outside the health system to support condom and lubricant distribution to the last mile.
- Increase access to and availability of condoms and lubricants for in-school and out-of-school youth, secondary schools, and higher education institutions (HEIs).
- Establish storage systems for condoms and lubricants at the community level.
- Establish quality assurance systems for condoms and lubricants.

Objective 2: Strengthen health systems for HIV combination prevention at all levels of service delivery.

Strategic interventions

- Develop and implement annual forecasting, quantification, and procurement plans.
- Strengthen national condom and lubricant distribution plans as informed by use, based on data including KP hot spot mapping data.
- Establish systems to effectively monitor the stock of condoms and lubricants at all levels.
- Integrate condom and lubricant supply chain indicators into health management information systems to improve the visibility of and accountability for commodities at all levels in the supply chain.

Objective 3: Strengthen leadership, governance, and coordination for HIV prevention at national and sub-national levels.

Strategic interventions

- Strengthen condom program coordination structures at national, district, and community levels.
- Strengthen generation of data and promote the use of data for decision-making at all levels of the health sector.
- Develop and effectively implement a robust condom and lubricant research agenda.
- Strengthen the capacity of all stakeholders, including the media, development partners, government departments, and district-level officials, to communicate effectively regarding condoms and lubricants.
- Develop an advocacy and public sector resource mobilization plan for sustainable condom programming.
- Enhance maintenance of the condom and lubricants information systems for needs estimation, monitoring, and evaluation.

Priority Area 2: Pre-Exposure Prophylaxis and Post-Exposure Prophylaxis

The Ministry of Health started providing oral PrEP services in Malawi in 2020 after a successful pilot conducted from 2019 to 2020. Since the rollout, there has been a steady increase in uptake of services, however the increase skewed toward KPs and AGYW at high risk. With the surge in HIV infections among pregnant and breastfeeding mothers, it is now imperative to integrate and scale up PrEP services into maternal health services. Furthermore, while daily oral PrEP is becoming more available and accessible, multiple barriers affect adherence to daily pill-taking — from stigma and patriarchy to pill size and side effects. In light of these challenges, the GoM and many stakeholders are optimistic that long-acting injectable PrEP can address many of the ongoing oral PrEP adherence barriers.

Objective 1: Increase access to, uptake of, and quality of PrEP services targeting high risk and priority populations in all high incidence districts.

Strategic interventions

- Support subnational planning for PrEP rollout and scale-up.
- Strengthen integration of PrEP with SRH, child health, and other service delivery points, including in the community outreach models.
- Improve human resource and health system capacity to offer PrEP, VMMC, STI services, and family planning through SRH/HIV service integration.
- Strengthen supply chain systems for PrEP medicines.
- Identify innovative strategies for mobilizing additional resources for oral PrEP scale-up and diversifying delivery channels, including the private sector- governance issue.
- Accelerate introduction and scale up for long-acting injectable PrEP.

Priority Area 3: Voluntary Medical Male Circumcision

The government has laid the foundation for the sustainability of the VMMC program in the country. This includes promoting the full integration, decentralization, task shifting, and use of World Health Organization (WHO) prequalified devices. The program continues to cultivate strong coordination and meaningful collaboration with partners and the private sector at all levels, while ensuring ownership of the VMMC program at district and community levels.

Objective 1: Increase access to, uptake of, and quality of VMMC services targeting high risk and priority populations in all high incidence districts.

Strategic interventions

- Integrate and routinize VMMC with other services and program management into Ministry of Health (MOH) structures across all levels.
- Build capacity for VMMC service delivery teams in all district facilities to optimize service delivery through the use of frequent site- and district-level data to continually assess productivity and potential underutilization.
- Equip facilities for local quality assurance and prioritize a decentralized mentorship approach to enhance quality assurance.
- Strengthen and expand waste management infrastructure to levels that are adequate for supporting service delivery.
- Support the transition of the VMMC program from the scale-up to the sustainability/maintenance phase.
- Strengthen VMMC commodities supply chain management at all levels through appropriate forecasting and close monitoring of commodity quantities and storage to be taken under the procurement and supply chain management (PSM) section.

Objective 2: Strengthen health systems for HIV combination prevention at all levels of service delivery.

Strategic interventions

- Strengthen the continued use of the national routine M&E system by all districts and implementing partners.
- Improve VMMC data management in all sites by integrating program tools into routine site M&E tools.
- Improve monitoring of program efficiency indicators to establish a comprehensive, responsive, and flexible M&E system that can support and meet the demands of the program across all levels of the health system.

Objective 3: Increase social acceptance and demand for VMMC interventions among key and priority population.

Strategic interventions

- Strengthen the use of a wide range of disciplines, including marketing, behavioural economics, and human-centred design, to inform targeted demand-generation strategies.
- Integrate VMMC demand creation across all health entry points, including PrEP and STI testing and treatment.
- Enhance the capacity and quality of community mobilization to maximize the impact of demand generation at the primary interface between the program and the client.
- Continuously monitor the market and changes in beliefs and values, and adapt the interventions used to maintain relevance and efficacy.

Priority Area 4: Key and Vulnerable Populations

Key populations are groups of people at an increased risk of acquiring or transmitting HIV due to their specific higher-risk behaviors. They often have legal and social issues related to their behaviors that increase their vulnerability to HIV. These social and legal issues, including stigma and discrimination, violence by both state and non-state actors, and restrictive laws and policies, constitute barriers to access and uptake of health services, including HIV testing, care, and treatment services.

Despite their substantial risk and vulnerability, KPs face a significant resource gap in interventions. Malawi shall prioritize scaling up innovative approaches and strategies to optimise access to and uptake of high-impact, evidence- and rights-based HIV combination prevention, including addressing structural barriers and inequality among key and vulnerable populations.

Objective 1: Increase access to, uptake of, and quality of HIV combination prevention interventions targeting high-risk and priority populations in all high-incidence districts.

Strategic interventions

- Expand differentiated service delivery models at various locations; scale up community-led service delivery, including HIVST; develop a sustainability plan for KP services.
- Expand stigma-free HIV prevention services through public and private facilities, safe spaces, and outreach clinics, as guided by the KP minimum package of services.
- Scale up prevention and treatment services among KPs to all districts in Malawi.
- Address structural barriers to promote access to care and treatment for KPs and survivors of violence.

Objective 2: Strengthen health systems for HIV combination prevention at all levels of service delivery.

Strategic interventions

- Improve the KP data management system.
- Support the conduct of high-quality, population-focused surveys such as population size estimates and programmatic and hot spot mapping, including factors that create inequalities in accessing and using services.
- Strengthen operational research to understand findings on interventions targeting KPs (including prisoners) that underpin drivers of inequality and formulate strategies for action.

Objective 3: Strengthen leadership, governance, and coordination for HIV prevention at national and sub-national levels.

Strategic interventions

- Strengthen the institutional capacity of KP-led organizations in program management.

- Strengthen peer education and navigation services.
- Strengthen sub-national KP TWG.
- Strengthen community-led monitoring in KP programming.

Objective 4: Mitigate structural and policy barriers that exacerbate HIV risk and vulnerability.

Strategic interventions

- Promote advocacy at all levels to decriminalize and normalize the rights of KPs.
- Strengthen victim support response mechanisms at all levels.
- Expand mental health and psychosocial support services to reach out to KPs.
- Enhance knowledge and awareness of law enforcers (police, military) and judicial officials on GBV protection policies, procedures, and accountability.
- Promote human rights and legal literacy among KPs and the community.

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Priority Area 5: Adolescent Girls and Young Women

Young people, especially AGYW, are highly vulnerable to HIV infections compared to older people. Factors associated with AGYW vulnerability are multifactorial. Young people, especially young females, lack comprehensive knowledge about HIV. Young women lack adequate SRH information; are not empowered to communicate with peers, potential sex partners, and adults regarding their needs; and often do not realize they are at risk. Not least, youth-friendly health services, although growing, are still limited. While some AGYW might know where to access services, most AGYW do not access services due to negative provider attitudes and/or not being able to afford the transportation costs to access services.

Objective 1: Increase coverage access, uptake, and quality of HIV combination prevention interventions targeting high-risk and priority populations in all high-incidence districts.

Strategic interventions

- Increase availability of high-impact combination HIV services for AGYW and their sexual partners to locations beyond the health system including community and youth centres.
- Strengthen and expand peer-led support structures/safe-space mentorship programs for AGYW, including 10- to 15-year-olds who are becoming sexually active early.
- Increase adolescent demand for HIV/SRHR and related services through intensified community-based, digital, and private sector approaches.
- Intensify access to high-quality, gender-responsive, age-appropriate comprehensive sexuality education services both in and out of school, with a focus on delaying sexual activity, preventing GBV, avoiding transactional and age-disparate sex, and building self-efficacy.

Objective 2: Mitigate structural and policy barriers that exacerbate HIV risk and vulnerability.

Strategic interventions

- Address the social and structural drivers of HIV in both rural and urban populations and institutions, including unequal gender norms and power dynamics and human rights violations across HIV prevention, treatment, and care efforts.
- Empower vulnerable AGYW through provision of social, economic, and legal interventions.
- Transform harmful social norms, providing supportive structural, cultural, and social systems.

Objective 3: Strengthen leadership, governance, and coordination for HIV prevention at national and sub-national levels.

Strategic interventions

- Intensify referral and linkages of AGYW to multisectoral interventions including sexual and reproductive health programs, social protection, and economic empowerment.
- Strengthen multisectoral coordination, collaboration, and linkages between key ministries and implementing partners.
- Strengthen the capacity of community-led support structures (youth organization/networks, CBOs) to coordinate AGYW interventions at the community level.

Objective 4: Strengthen health systems for HIV combination prevention at all levels of service delivery.

Strategic interventions

- Strengthen the data collection/management/monitoring/reporting system at national, district, and community levels.
- Support community-led monitoring and research and ensure that community-generated data are used to tailor responses to the needs of AGYW.

Objective 4: To strengthen the monitoring and reporting of AGYW.

Strategic interventions

- Strengthen the data collection/management/monitoring/reporting system at national, district, and community levels.
- Conduct ongoing formative research to determine the effectiveness of AGYW service delivery.
- Support community-led monitoring and research and ensure that community-generated data are used to tailor responses to the needs of AGYW.

Priority Area 6: Adolescent Boys and Men

Adolescent boys and men have distinct health needs and vulnerabilities and engaging them can benefit everyone — especially other vulnerable populations such as AGYW and breastfeeding mothers. Low rates of male testing and treatment increase HIV transmission and affect their partners, families, and communities. Men's low utilization of services is not

just the consequence of individual behaviour but also is related to structural factors that limit the adequate provision of services.

Multifaceted tailored interventions that address adolescent boys and men's needs, aspirations, and preferences are required to put men at the centre of these services. This will necessitate planning and implementing client-centred strategies that fit clients' lives and provide services that are easy to access.

Objective 1: To increase access to and uptake of HIV prevention among adolescent boys and men.

Strategic interventions

- Improve health literacy and health-seeking behaviours by improving the supply, quality, and accessibility of health information.
- Expand community-led services, including availability and accessibility of targeted HIV prevention and SRH services.
- Improve access to and utilization of condoms and lubricants and uptake of VMMC services.
- Optimize differentiated testing approaches, including community-based index testing and self-testing, facility-based testing of antenatal care (ANC) partners, and workplace self-testing.

Priority Area 7: Elimination of Mother-to-Child Transmission

In 2010, Malawi pioneered the use of lifelong ART among pregnant women living with HIV (Option B+), which was later adopted globally as the best practice and standard of care for the PMTCT program. The national program has consistently made giant strides; as of 2022, new paediatric infections had been reduced to 2,500 from 15,000 in 2010. Mother-to-child transmission is estimated at 2.3% at six weeks and 5.7% at the end of the breastfeeding period. The country is now moving toward triple EMTCT of HIV, congenital syphilis, and viral hepatitis. As of 2022, 98% of women attending antenatal care were screened for HIV, a remarkable advance from 49% in 2010. Syphilis screening among pregnant women is at 67%. Screening for viral hepatitis started in 2022, and plans for scale-up are underway. Option B+ coverage has remained consistently high since 2010, ranging from 98 to 100%.

Though the country has made progress in eMTCT of HIV, some challenges still exist. These include low levels of retention of mothers and children on ART; suboptimal syphilis screening among pregnant women; and low EID coverage; more than 50% of new pediatric HIV infections occur during the breastfeeding period from women who are seroconverting, most likely newly infected from their spouses; and loss to care among women already on ART.

Objective 1: Increase access to, uptake of, and quality of eMTCT services targeting women of childbearing age in all districts.

- Increase demand for HIV combination prevention and SRH services among at-risk AGYW, FSWs, young mothers, and pregnant women by developing specific messages

to empower women to make decisions to seek HIV prevention services and an information package targeting men.

- Increase access to and uptake of comprehensive biomedical HIV prevention services (PrEP, STI screening, VMMC, condoms, HTS) among AGYW, FSWs, young mothers, and pregnant women and their partners.
- Engage community structures and networks to promote early ANC services and skilled delivery.
- Intensify adherence support to pregnant and breastfeeding women and their partners on ART.
- Increase access to viral load (VL) monitoring among pregnant and breastfeeding women and their children on ART.
- Strengthen HIV prevention and care and treatment services targeting young pregnant women attending young mothers' clinic or SRH services.
- Intensify identification and provision of prophylaxis to infants at high risk of HIV through development and distribution of a poster on the pathways for identifying high-risk exposed infants.
- Promote HIV screening of HIV-exposed infants at six weeks after birth and testing at 12 months and/or when breastfeeding ends, as recommended by WHO to promote linkage to ART by decentralizing infant HIV testing to primary health care facilities in high HIV burden areas.
- Strategically scale up distribution of POC devices to geographically hard-to-reach areas and districts with high HIV incidence among pregnant and breastfeeding women
- Scale up community mobilization targeting men to boost male involvement in partner's antenatal care services.
- Scale up mother-infant pairs clinics for HIV-positive breastfeeding women and their exposed infants.

Objective 2: Reduce mother-to-child transmission of HIV, syphilis, and hepatitis B in pregnant and breastfeeding women.

Strategic interventions

- Scale up testing and linkage for partners of pregnant and breastfeeding women in high HIV burden districts through use of HIV self and index testing.
- Increase retesting of at-risk HIV-negative mothers during pregnancy and breastfeeding in maternal and child health, under-five, and postnatal and family planning clinics.
- Strengthen linkage to HIV, syphilis, and hepatitis B treatment and care for infected pregnant and breastfeeding women and their infants. Strengthen integration of eMTCT (messaging, HIV screening, and linkage) into postnatal, Expanded Programme on Immunization, and family planning services
- Strengthen linkage to care for all children who are identified as HIV and/or hepatitis B positive.

Objective 3: Strengthen health systems for HIV combination prevention at all levels of service delivery.

Strategic interventions

- Improve human resource for health (HRH) for testing services targeting districts with high HIV incidence among pregnant and breastfeeding women and non-partner-supported facilities.
- Provide ongoing capacity building and training to service providers to provide integrated testing services.
- Improve the availability of commodities for testing services and sustain accessibility to diagnostics and ART in maternal and child health services, especially in high HIV burden and remote areas. Delivery of these commodities must ensure that they are timely, appropriate, high quality, and equitable.
- Improve turnaround time for EID sample results in all facilities.
- Develop and implement low-tech longitudinal registers to track mother-infant pairs and an updated monitoring framework in all ART sites to promote infant testing when mothers report to collect their ART.
- Develop and pilot short message service (SMS) technology for mobile health (mHealth) initiatives to remind women of the next EID and the importance of having their babies tested for HIV.
- Strengthen routine quality improvement initiatives for EID services including updating existing tools, data validation, mentorship, and supervision.
- Fast-track the revision and distribution of M&E tools to incorporate documentation of changes made in the new policies on PMTCT including documentation for high-risk exposed infants in the maternity unit.
- Strengthen adherence support by recruiting and deploying social workers to the facility and in the community to provide psychosocial support services for pregnant and breastfeeding women on ART.
- Strengthen defaulter tracing by recruiting and deploying CMAs in districts with high HIV incidence among pregnant and breastfeeding women.

Priority Area 8: STI, SRH, and GBV Services

STIs have a profound impact on sexual and reproductive health globally. Investments in STI management will contribute to the reduction of new HIV infections. Approaches to reduce the incidence of STIs include primary and secondary interventions. Malawi is currently using the syndromic management approach integrated with other services.

Objective 1: Increase access to, uptake of, and quality of STI, SRH, and GBV services, targeting high-risk and priority populations in all high-incidence districts.

Strategic interventions

- Increase access to and utilization of STI syndromic screening and treatment services.
- Improve the quality of STI case management in public and private health facilities.
- Strengthen integration and linkage of STI services with other services.
- Strengthen the Neisseria gonorrhoea antimicrobial resistance sentinel surveillance system.
- Strengthen screening and treatment of women living with HIV for cervical pre-cancerous lesions.

- Strengthen integration of service delivery of STI and SRH services including family planning and cervical cancer screening and treatment services.
- Strengthen engagement and collaboration with the private sector on STI and HIV prevention service delivery.

Priority Area 9: Differentiated HIV Testing Services

While it is generally accepted that HIV testing is not in itself a preventative measure, it is the gateway to HIV services, both treatment and preventive. While HTS have been increasingly geared toward finding HIV-positive people and linking them to care and treatment, HTS also plays a role for those who test negative, as they can be linked to prevention interventions and reassured that the HIV prevention measures, they are following are successful and should be continued. The increasing availability of HIVST can also play a role in this positive reinforcement.

Objective 1: To improve case finding among high-risk populations through proven innovative approaches.

Strategic interventions

- Improve access to HIV testing in line with the integrated testing guidelines.
- Conduct targeted testing according to specific age groups, sex, populations, and their geographical areas where there is high incidence and more undiagnosed PLHIV.
- Strengthen targeted facility and community testing of all key and priority populations including men and children.
- Conduct differentiated service delivery to men, women, adolescents, and children so that they can access testing, treatment, and prevention services in friendly areas and at convenient times.
- Improve the quality of HTS diagnoses through better planning, management, and quality assurance systems.
- Improve HTS data systems at the facility and community levels.
- Improve governance and coordination of the HTS program across the public and private sectors with a focus on decentralization to improve access to testing services.

Objective 2: To support the scale-up of high-impact interventions to reduce transmission, related morbidity, and mortality.

Strategic interventions

- Strengthen provider-initiated testing and counselling (PITC).
- Scale up ethically safe index and social network testing services for all key and priority populations at facility and community levels.
- Strengthen HIVST for all targeted populations through scale-up of the primary and secondary distribution across all facility and community entry points.

- Integrate testing in other health-related services such as SRH, and in prison and humanitarian settings.
- Conduct venue-based testing in the community such as moonlight in hot spots.
- Repeatedly ascertain HIV status among women during pregnancy and breastfeeding according to the integrated testing guidelines in order to identify incident maternal infections and return women who have interrupted treatment to ART; this is a key HTS program contribution toward EMTCT.
- Strengthen use of evidence-based interventions and best practices through conducting operational research as well as M&E.

Objective 3: To effectively link individuals and their families to appropriate treatment, care, and support as well as prevention services.

Strategic interventions

- Strengthen active referral to HIV prevention, treatment, care, and support services.
- Re-test all back-to-care individuals for re-engagement.
- Strengthen counseling services to support behavior change and treatment adherence.

Priority Area 10: Treatment as Prevention

Prevention as treatment (TasP) is a public health concept that promotes the use of ARV drugs to prevent and reduce the transmission of HIV from an individual living with HIV to a person not living with HIV. This concept is complemented with screening all eligible clients for noncommunicable diseases (NCDs) and referring them to care. TasP refers to HIV prevention methods and programs that use ART to decrease the risk of HIV transmission. The efficacy of using treatment as a prevention strategy depends on early case finding, prompt linkage to treatment, excellent adherence to treatment, and ultimately, achieving and sustaining an undetectable VL, as well as actively following up clients categorized as interrupted in treatment to determine true defaulters and bring them back to care.

According to third quarter 2022 program data, 2,445 individuals were classified as having interruption in treatment. This group constitutes true defaulters, deaths, and silent transfers. Those who have defaulted treatment contribute to HIV transmission by VL rebound and infecting others. Active follow-up of all patients with interruption in treatment is key, as this will allocate accurate treatment outcomes for all patients who died, were silently transferred to another facility, have no trace at all, and were identified as having disengaged from care due to personal or health system factors.

PLHIV who are adherent on ART may attain undetectable levels of HIV in their blood (viral suppression) to the extent that they have a low or zero risk of transmitting HIV. Studies and the epidemic trends in settings where HIV treatment has been massively scaled up confirm that ART is a potent tool in preventing HIV transmission. However, gaps exist in VL coverage across the VL cascade for all age groups and sexes. These challenges include sample collection, transportation, laboratory processing, results return, and results utilization. Identifying and resolving these issues will allow a more attractive VL program that will allow

early detection of high VL that contributes to incident cases of HIV. VL suppression among patients on dolutegravir (DTG) ranged from 93% to 95% in 2022. Additional work is required to achieve the NSP targets of 95% by 2025.

Furthermore, as part of a TasP package, Malawi is rolling out the undetectable=untransmissible (U=U) campaign in a contextualized version known as T=T (*Tizirombo tochepa = Thanzi*). The T=T campaign is envisaged to raise awareness about HIV treatment and its benefits among infected and uninfected people. The campaign will be used to make HIV treatment attractive to those already on treatment and the newly diagnosed by promoting treatment adherence as a means to viral suppression and quality of life at an individual level.

The MPHIA 2020–2021 revealed that men lag in the awareness of their status, with 85% aware, compared to 90.4% of women, which shows some gaps in testing. Targeted testing of men will allow the identification of positives and linkage to treatment, thereby reducing chances of additional transmission. This will increase the chances of early detection of high VL from resistant strains as well as from poor adherence, which contribute to incident HIV cases.

Objective 1: Increase access to, uptake of, and quality of VL testing services in all districts.

Strategic interventions

- Roll out U=U messaging at the community level.
- Increase awareness among service providers on protocols for HIV resistance testing.
- Improve quality of pre-treatment counselling.
- Scale up differentiated drug delivery approaches that suit clients' working and social realities.
- Optimize multi-month dispensing of ART.
- Improve health care provider attitudes.
- Transition all clients to optimal ARV regimens (single tablet, once daily, and most tolerable regimen)
- Support provision of back-to-care package to clients who re-engage in care (advanced HIV disease screening, mental health screening).
- Expand psychosocial support in communities for people living with HIV to improve adherence.
- Screen and refer to care all eligible clients for NCDs.

Objective 2: Strengthen health systems for VL services at all levels of service delivery.

- Address barriers to VL monitoring within the VL cascade to make the service accessible to all, including reducing the turnaround time for test results and prompt delivery of results to clients.

- Engage the private sector to include VL monitoring within their package of HIV services.
- Design and update the national protocols for managing clients with unsuppressed VL; improve systems for early identification and management of clients with unsuppressed VL.
- Address the knowledge gap for providers when faced with persistent high VL despite enhanced adherence counselling.
- Strengthen the defaulter tracing program for all clients lost to follow-up using community health workers, expert clients, community volunteers, and other community structures.

Priority Area 11: Blood and Blood Product Safety

In line with the 2023–2027 Malawi Extended NSP for HIV and AIDS, the GoM will support the Malawi Blood Transfusion Service (MBTS) to develop and implement interventions to grow the blood donor base and increase blood collections to meet at least 80% of national targets for blood needs estimated at 180,000 (based on WHO estimation method of using 1% of total population) whole blood donations per year with the aim of reducing HIV infections, syphilis, and hepatitis B and C in recipients, of which the majority are children and pregnant mothers.

A sustainable funding strategy for blood services will enable MBTS to implement blood collection activities, process blood into blood products, and distribute to all hospitals authorized to carry out blood transfusions in Malawi. MBTS will improve timely access to blood products. MBTS will decentralize blood distribution to reduce the distances hospitals cover to collect blood. Critical support for MBTS will include financial resources to improve infrastructure, human resources, equipment, and commodities for these processes, and M&E of blood safety, including hemovigilance.

Objective 1: To increase access to supplies of safe blood and blood products from MBTS.

Strategic interventions

- Reduce waiting time for blood transfusions.
- Build capacity of decentralized blood storage units in the district hospitals by establishing and building capacity for new blood distribution points (Karonga, Kasungu, Chikwawa, Mulanje, and Mangochi).
- Upgrade Balaka satellite depot into a full transfusion centre.
- Explore usage of drones in transporting blood products to hard-to-reach areas.
- Support demand creation for donations in institutions of learning.
- Increase and improve advocacy information, education, and communication (IEC) and mobilization for blood donation in communities.

Objective 2: Strengthen health systems to provide high-quality and safe blood transfusion services

Strategic interventions

- Align blood transfusion services to international/national standards; improve capacity for transfusion medicine; strengthen infrastructure and the cold chain for transfusion services.
- Contribute to review of key blood safety documents (Clinical Use of Blood Guidelines, Guidelines for Blood Transfusion, Blood Policy, communication strategy, and Blood Mobilization strategies).
- Strengthen referrals and linkage pathways for blood donors requiring HIV services.
- Acquire Level 2 accreditation by African Society for Blood Transfusion by 2025.
- Provide quality testing and processing of all collected blood.
- Strengthen haemovigillance in transfusion facilities.
- Conduct blood safety trainings for all cadres involved in the blood transfusion process.
- Ensure sustainable financing for blood transfusion services.
- Optimize tracking and promotion of repeat donations among people who have ever donated.

Priority Area 12: Social and Behaviour Change Communication

SBCC is a crosscutting strategy that should be applied across all pillars and interventions to optimize the intended outcomes. SBC interventions are evidence-based, organized efforts that combine innovation and creativity to deliver messages that motivate individuals, families, communities, organizations/institutions, policymakers, and social systems to change behaviours and social norms.

This SBCC plan for HIV prevention is guided by the Social-Ecological Model (SEM) theory. This theory-based framework helps to explain the multilevel factors that determine behaviours and identify behavioural and organizational leverage points and intermediaries for health promotion.

SBCC interventions will be implemented through three key elements, which are:

- Advocacy to create enabling policy, legal, and service access environments while also addressing structural barriers
- Social mobilization for broader participation, collective action, and ownership, including community mobilization
- Behaviour change communication (strategic communication) for changes in knowledge, attitudes, and practices of specific audiences

Implementation of SBCC in this strategy will use traditional and innovative digital platforms including social media.

The SBCC plan aims to help increase and sustain the uptake of HIV prevention, treatment, and care services among priority populations across the thematic areas.

This section provides an SBCC plan and guidance for developing and implementing SBCC campaigns/interventions aimed at changing HIV-related behaviours, attitudes, and social norms at multiple levels of the social system.

Objective 1: Increase social acceptance and demand for HIV combination prevention interventions among key and priority populations.

Strategic interventions

- Enhance knowledge levels regarding the benefits of correct and consistent condom and lubricant use among key and priority populations.
- Advocate for sustained availability of and access to condoms and lubricants based on the last mile strategy.
- Increase knowledge regarding prevention options, including PrEP, PEP, and condoms, among key and vulnerable populations.
- Address legal and structural barriers that affect the uptake of services among KPs.
- Promote access to and uptake of HIV prevention, including SRHR services among AGYW.
- Address negative cultural and social norms that perpetuate early and child marriages.
- Increase knowledge among KPs, their clients, and the general population regarding STIs and STI diagnosis and treatment.
- Advocate for improved financing and availability of STI drugs for sustained supply.
- Address context-specific social and cultural norms that affect VMMC service demand and uptake.
- Integrate VMMC demand creation in institutions of learning and community activities.
- Increase knowledge on the importance of continuing ARV drugs after giving birth.
- Intensify SBCC to increase demand and uptake of HIV prevention and SRH services among at-risk AGYW, FSWs, young mothers, pregnant women, and their partners.
- Promote innovative testing approaches such as HIVST, index testing, and sexual network testing.
- Increase knowledge of PrEP and its benefits among target audiences, including their partners.
- Address myths and misconceptions that affect PrEP uptake and sustenance.
- Increase knowledge regarding the importance of treatment and treatment adherence.
- Address religious and cultural beliefs that affect treatment adherence.
- Increase knowledge regarding the importance of blood donation.
- Address misconceptions regarding blood transfusion

Priority Area 13: Monitoring and Evaluation

Data-driven solutions would improve access to high-quality HIV services for marginalized populations, including children, AGYW, and KPs. With support from its collaborating partners, the M&E component will focus on objectives to address the outstanding gaps and challenges. This will also ensure seamless integration of data utilization within the HIV prevention landscape. The M&E objectives and supporting interventions for the HIV Prevention Framework will be as follows:

Objective 1: Leverage and build upon existing HIV Prevention M&E systems and service delivery platforms.

Strategic interventions

- Integration of HIV prevention and treatment data systems through technical and financial support to M&E systems across levels to promote data analysis and utilization.
- Support and build capacity of the district M&E systems through regular review meetings, among other things.
- Identify mechanisms to promote and enhance community HIV data systems and feedback.
- Promote and support data use to inform program management and decision-making at all levels.

Objective 2: Establish mechanisms to control and regulate digital data packages coming into the HIV prevention technical area.

Strategic interventions

- Advocate for the establishment and operationalization of a digital health advisory group with clear terms of reference for managing all HIV digital data solutions in the country, establishment of mechanisms for legislation, and regularizing of HIV/AIDS data packages.
- Support ongoing work with unique identifiers and national registration.
- Identify key prevention cascades and customize populating and reporting at all levels.
- Promote private-public and community-based sharing of data for programmatic purposes.

Objective 3: Promote research, innovation, knowledge management, and dissemination of findings.

Strategic interventions

- Facilitate prioritization and implementation of studies of national interest to inform HIV programming.
- Facilitate the production of information briefs to inform decision-making.
- Coordinate and hold Annual Research Conferences on HIV Prevention and Services, support Joint Sector Reviews, and share findings at all levels.
- Facilitate identification of priority populations in locations or communities that may not be apparent through a mainstream public health approach.

Objective 4: Leverage available data to identify inequality markers/frameworks to improve service access, utilization, and impact.

Strategic interventions

- Further analysis of existing datasets to identify disparities/inequalities thereby contributing to quality of prevention services, access, utilization, outcomes, and impact.
- Using community dialogues to identify drivers of inequalities contributing to disparities within the contexts.

- Collectively formulate key actions/compound actions points for joint programming to address the drivers of inequalities.
- Development of models to project impact of addressing inequalities.

3.4. Procurement And Supply Chain Management

To ensure uninterrupted availability of prevention-related commodities throughout the supply chain, all the commodities required will be incorporated into the existing Procurement and Supply-chain Management System for HIV commodities managed by the Department of HIV and AIDS and Viral Hepatitis (DHA). Annual national quantification and supply planning will guide stock requirements for commodities and shipment scheduling. Stock levels of program commodities will be maintained six to nine months at the central warehouse level and two to four months at the health facility level.

Health facilities will be directly restocked bimonthly from the central warehouse. To determine the number of commodities each facility needs, data collected every quarter through integrated TB/HIV supervision and reported through the Logistics Management Information System will be utilized for patient numbers, stock on hand, consumption, adjustments, and quantity required.

TABLE 3. COMMODITY GROUPS MANAGED WITHIN THE DEPARTMENT OF HIV/AIDS TO SUPPORT THE PREVENTION STRATEGY

Commodity group	Examples	Supply*
Rapid tests	HIV, viral hepatitis, and syphilis rapid test kits	E
ARVs	TDF/3TC 300/300mg TDF/FTC 300/200mg	E
STI	Standard/alternative antibiotics (e.g., acyclovir, clotrimazole)	S
VMMC	Shang Rings, conventional circumcision kits	E
PIFP	Male condoms, female condoms, lubricants	S
Cervical cancer	Cervical cancer screening tools	S
Blood safety products	Blood safety reagents and consumables	S

*E=Item managed exclusively through HIV Program, S=Item supplemented by diagnostics department for HIV Program

At the health facility level, commodities including those for outreach clinics will be ordered from the pharmacy/drugstore using requisition/issue booklets (RIV). After every community outreach activity, commodity returns will be kept at the mother facility in a secure lockable room/cabinet within the ART clinic/pharmacy. Physical counting of supplies must be done monthly and during the handover to ensure proper accountability.

Documentation (e.g., stock cards, RIVs, relocation books, daily activity registers) for commodities within the health facility and community outreach clinics must be maintained and accessible by supervisors for supervision, mentorship, support, audit, and accountability.

Communication to DHA on any PSM-related issues will be through toll-free lines (59191 — Airtel and 6882 — TNM) or by email (hivdeptlogistics@gmail.com) for support and

authorization codes. Adverse drug-related issues will be reported to Pharmacy Medicines Regulatory Authority (PMRA) through the online platform Medsafe360 and manually using the adverse drug reaction forms and submitted to a district pharmacist for submission to PMRA.

Chapter 4: Implementation Arrangements

Successful implementation of the HIV Prevention Framework (2023–2027) will depend on strong and functional systems, including leadership. Within the governance, coordination frameworks explained in the above sections and the actual implementation of the framework is the responsibility of a range of implementing partners from the public and private sectors and civil society. The implementation arrangement has modelled the National HIV Strategic Plan (2020–2025). However, implementation will include:

- Ministry of Health and Population
- National AIDS Commission
- Central and other line Ministries including the Department of Human Resource Management (DHRMD)
- Local Authorities
- Nongovernmental Organizations (NGOs), Faith-Based Organizations (FBOs), and Community BOs coordinated through Malawi Network of AIDS Service Organizations (MANASO), Malawi Network of People Living with HIV (MANET+), Malawi Interfaith AIDS Association (MIAA), and National Youth Council of Malawi (NYCOM)
- Private sector organisations under the coordination of the Malawi Business Coalition against AIDS (MBCA)
- Development Partners

4.1. Monitoring and Evaluation of the HIV Prevention Framework

Combined approaches will be used to monitor and evaluate the HIV Prevention Framework (2023–2027). Data on the inputs, process, outputs, outcomes, and impact of the interventions will be collected by key players at different points.

The evaluation process will focus on collecting data at the outcome and impact levels. Refer to the results matrix (Annex 11.2) for specific performance indicators (outcome and impact level), indicator definitions, and data collection methods.

The strategy prioritizes collecting and effectively using data to promote decisions across levels instead of collecting data to forward upwards. Routine data quality assessment and utilization efforts remain key to advancing the strategy. These efforts will assess progress toward the realization of quality data systems and commitment to digitization and utilization of real-time data as much as possible. Additional requisites include improved collection, analysis, and use of data to better inform the HIV and AIDS response. This will also entail greater use of community-generated and -owned data to monitor the affordability, availability, accessibility, acceptability, and quality of HIV prevention interventions for different groups.

4.2. Community-Led Monitoring and Evaluation

Community, school, and facility-based activities will be monitored throughout the implementation. It is recommended that the communities take the lead in monitoring community engagement activities, which will require intensive capacity-building initiatives, including training and on-the-job learning. Implementing partners will need to make frequent monitoring visits to the implementation sites. It is imperative to develop standardized monitoring tools across the board. Implementing partners may adapt the tools accordingly.

4.3. Documentation f Case Studies and Success Stories

One of the most reliable community-led monitoring and evaluation methods is documenting "most-significant-change" stories from the communities. Stories of change could be written as clear and compelling narratives using available data collected from monitoring and knowledge management activities during the implementation phase. Additional interviews may be conducted with beneficiaries if necessary. A video documentary could also be

produced to pin together all the achievements and lessons learned during implementation. The aim is to demonstrate and document key successes and stories of change brought about by implementing HIV prevention interventions.

4.4. Costing of the HIV Prevention Framework (2023–2027)

The HIV Prevention Framework (2023–2027) has used the activity-based costing approach from a payer perspective (e.g., government, civil society, NGOs, and the private sector). Activity-based costing involves identifying each activity associated with achieving the programmatic goals or objectives of the strategy. The method assumes that discrete activities that consume resources produce outputs or services. All the relevant resource items for the activities have been identified and measured separately, thus improving the accuracy and reliability of the cost estimation and, ultimately, allowing for the identification of duplications or synergies. This helped in harmonization and led to potential efficiencies within activities, so that the HIV Prevention Framework delivers the greatest impact for the money.

The starting point for the costing is the program objectives for the strategy. Each objective was broken down into service delivery and programmatic interventions. Service delivery interventions were further disaggregated at the level deemed appropriate by technical staff through consultation (e.g., geographically, service delivery point, KP). The top-down objective-setting combined with a bottom-up costing (Figure 15) allows service delivery and the achievement of service delivery objectives to be costed on a cost-per-client-reached basis.

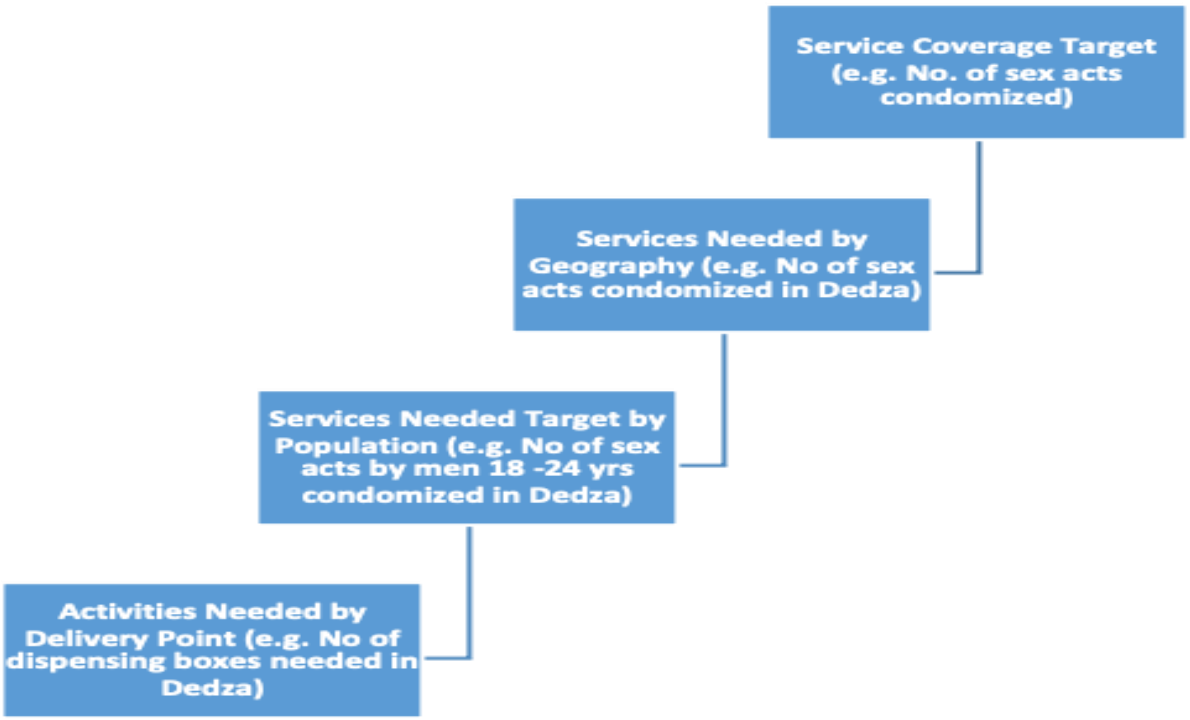


FIGURE 15. COSTING USING A BOTTOM-UP APPROACH

For programmatic interventions, a detailed list of supportive activities (e.g., supervision, training, policy development) needed to achieve the program objectives was generated and

validated during the HIV Prevention Framework (2023–2027) development. These activities were not related to service delivery, but instead, were needed to enable or support high-quality service delivery.

The costing assumptions or resource items needed for both service delivery and supportive activities were defined through a participatory process. Rounds of activity validation meetings were held between the costing team, team of consultants, NAC and DHA officials, and other stakeholders to ensure that costing assumptions and computations are accurate, logical, consistent, and comprehensive.

CHAI has developed a new comprehensive and user-friendly Excel costing tool, which was used to cost the HIV Prevention Framework (2023–2027). Stakeholders from NAC, DHA, and the MOH have been trained on the usage of this tool. Using this tool, CHAI has established costs based on current guidelines and unit costs as well as historical financial records and budgets, which in turn were applied to annual quantities informed by results framework targets. With the aid of involved stakeholders, the exact cost sources were defined.

Established activity-level costs were further used in the financial gap analysis. The projected costs of the HIV Prevention Framework were compared to the projected funding envelope for HIV in Malawi, as currently budgeted by the GoM, development partners, NGOs, and Christian Health Association of Malawi (CHAM). For this purpose, the MOH's annual resource mapping exercise was used to provide a macro-level consolidated look at the health sector budget across districts, disease programs, interventions, and cost categories. Conducting a financial landscape analysis by comparing the HIV Prevention Framework funding needs to resource mapping data will help improve coordination, budgeting, and planning of the health programs. The current resource mapping exercise covers fiscal years 2019–2020, 2020–2021, and 2021–2022.

Annexes

Annex 1. HIV Prevention Messaging Framework Per Thematic Area and Social-Ecological Model Target Audience

Condoms and Lubricants

Goal: Increase demand and uptake of condoms among high-risk, vulnerable, and key populations				
Target Audience		Desired Outcome	Barriers[3]	Strategic Approaches
Primary Target Audiences	FSWs CFSWs Sero-different couples	FSWs access condoms freely FSWs use condoms correctly and consistently. High uptake of condoms among FSWs	Stigma relating to condom access. Intermittent supply of condoms Limited skills in usage of female condoms Negative attitude toward female condoms	Demand creation for condoms Support sex worker cadres to advocate for and engage with health care workers (HCWs) to access condoms. Conduct hot-spot-level condom activation campaigns using audio-visuals. Orient peer cadres on female condom use. demonstrations. Conduct continuous barrier analysis studies to understand the underpinning factors of low condom uptake
		CFSWs understand the importance of and use condoms correctly and consistently	Low risk perception The perception that male condoms diminish sexual pleasure. Alcohol use, mostly among men, contributes to unprotected sex	Demand creation Conduct social media campaign on condom use. Conduct condom use activation sessions in hot spots. Advocate for public-private partnerships (PPPs)
		Sero-different couples use condoms consistently and correctly	Low risk perception Low self-efficacy to adopt HIV preventive measures among women due to low levels of education and	Demand creation Conduct mass media campaign on condom use. Orient support groups on condom use promotion. Train support groups to conduct dialogue sessions on condom use.

[3] Refer to Annex 3 for additional barriers per thematic area.

			economic dependence on men. Low rates of disclosure of HIV status and notification of partners due to fear of domestic violence/abandonment The perception that male condoms diminish sexual pleasure	Promote condom use negotiation among sero-different couples.
	Adolescent boys and girls	Adolescents access and use condoms freely	Limited comprehensive knowledge of the benefits of condom usage Gender and power imbalances that disempower women, girls, and young boys	Demand creation Conduct peer-led interventions in hot spots through peer educators (PEs) and peer navigators (PNs) to create demand for condoms and lubricants. Implement a targeted social media campaign to promote condom use. Orient youth groups on condom use promotion. Conduct mass and social media campaigns to empower AGYW to negotiate condom use
	Prisoners	Prisoners use condoms during sexual encounters	Policies and regulations that restrict access to condoms in prisons	Legal and policy framework Advocate for synchronizing policies, procedures, and regulations Advocate for utilization of peer-led community structures for condom distribution
Secondary Target Audience	General population Community Traditional counsellors		Poor access and availability of condoms	Develop and implement a branded mass media campaign on condoms and lubricants. Implement a mass media campaign on consistent and correct condom use. Advocate for community condom distribution points Support youth clubs and groups to access and distribute condoms among peers. Advocate for review of conflicting policies on SRHR access

				Conduct a community outreach campaign that uses mobile videos and targets adolescents. Promote utilization of peer-led community structures for condom distribution
			Stigma associated with condom use	Conduct a media campaign by building the capacity of community radios with HIV programming targeting sero-different couples
		Traditional counsellors to promote condom use during initiation ceremonies		Orient traditional counsellors (e.g., Angalibas) on condom use promotion among initiates
Tertiary Target Audiences	Policymakers Service providers	Condom distribution in traditional ceremonies Condom distribution through peer-led community structures		Lobby for the distribution of condoms during initiation ceremonies Advocate for utilization of peer-led community structures for condom distribution
			Poor attitudes among HCWs	

Key and Vulnerable Populations

Communication Goal: Increase access to and uptake of combination HIV prevention, treatment, care, and support among KPs				
Target Audience		Desired Outcome	Barriers	Key Activities
Primary Target Audience	KPs	FSWs are accessing HIV prevention and SRHR services, including condoms and lubricants	Intermittent condom supply chain Limited comprehensive knowledge of HIV prevention and SRHR services (PrEP)	Demand creation for services Intensify peer-led interventions in hot spots through peer education and peer navigation services to strengthen demand for HIV prevention, treatment, and SRHR services. Conduct condom use activation sessions in hot spots.

			Limited knowledge of treatment literacy	Conduct orientation of hot spot owners to promote condom use among FSWs
		Improve treatment literacy among KPs	Lack of knowledge and skills	Treatment Train PEs/PNs on PrEP Intensify treatment literacy and PrEP peer sessions among peers
	MSM	MSM access condoms freely MSM use condoms correctly and consistently. High uptake of condoms among MSM	Stigma related to condom access. Intermittent supply of condoms Perception that male condoms diminish sexual pleasure.	Demand creation Support MSM peers to advocate for and engage with HCWs to access condoms. Conduct social media campaign on condom use within hot spots. Conduct condom-use activation sessions in hot spots. Advocate for PPPs Conduct continuous barrier analysis studies to understand underpinning factors to low condom uptake
	Male sex workers	Male sex workers to access condoms freely. MSW to use condoms correctly and consistently. There is high uptake of condoms among MSW	Stigma relating to condom access. Intermittent supply of condoms The perception that male condoms diminish sexual pleasure.	Demand creation Support MSW peers to advocate for and engage with HCWs to access condoms. Conduct social media campaign on condom use within hot spots. Conduct condom use activation sessions in hot spots. Advocate for PPPs Conduct continuous barrier analysis studies to understand underpinning factors to low condom uptake
Secondary Target Audience	General Population			Develop and implement a branded treatment literacy mass media campaign using print, radio, and television

	Community		GBV	Establish and train district GBV support groups to address GBV among KPs Support district GBV response team meetings at the district level Reorient PEs on GBV prevention and reporting. Conduct hot spot awareness/activation campaigns to raise awareness about GBV, GBV response, and reporting mechanisms
	CFSWs	CFSWs access and use condoms correctly and consistently	Low-risk perception Fatalism	Conduct hot spot awareness/activate branded campaigns to raise awareness about GBV, GBV response, and reporting mechanisms. Identify and train condom champions in hot spots to promote condom use among peers
	PWID	PWID access clean and sterile syringes and needles	Sharing of needles and syringes common	Conduct awareness on the dangers of needle and syringe sharing. Promote distribution of sterile needles and syringes
Tertiary Target Audience	Faith and traditional leaders	A supportive environment for the key and vulnerable population is created and sustained	Cultural and normative beliefs Inadequate knowledge of the rights of KPs	Awareness Conduct sensitization meetings among traditional and religious leaders about KPs (FSWs, MSM, trans people) Sensitize and engage local faith, traditional, and community leaders and prison top management in social dialogue to foster a supportive environment for KPs Advocacy Conduct dialogue sessions on KP rights and responsibilities among traditional and faith leaders
	Law enforcers, judiciary, and social welfare	The policy and legal environments are revised to be supportive of the needs of KPs	Lack of clarity on the policy and legal environments for specific KPs Lack of knowledge about the social and SRHR needs of KPs.	Awareness Conduct orientation sessions among the judiciary, law enforcers, human rights bodies, and social welfare groups to enhance knowledge and awareness of policies and laws relating to KPs and address the stigma that affects KPs

			Lack of clear policies and legal provisions in the constitution and penal code	
				Advocacy Conduct a literature review to establish the policy and legal frameworks regarding trans people. Conduct advocacy meetings to review policies and laws related to trans people. Conduct advocacy meetings to influence the review of policies and laws that affect programming for KPs (FSWs, MSM, trans people)
			Unfriendly services limiting KP access to clinical services. Negative attitudes towards KPs among some HCWs	Structural barriers Orient HCWs on the provision of stigma-free clinical, legal, and social services

Transgender People

Communication Goal: Increase access to and uptake of combination HIV prevention, treatment, care, and support among trans people				
Target Group		Desired Outcome	Barriers	Key Activities
Primary Target Audience	Trans community	Trans community has self-confidence	Self-stigma generated from community perceptions and attitudes	Social media campaign
Secondary Target Audience	Community — traditional and religious leaders	Increased knowledge and understanding of trans people	Lack of knowledge regarding the trans community	Conduct orientation sessions on trans and human rights among traditional and religious people. Conduct advocacy meetings with policymakers regarding the needs of the trans community
Tertiary Target Audience	Policy and legal environment	The policy and legal environments are	Unclear policy and legal environments	Conduct a literature review to establish the policy and legal frameworks regarding trans people.

		clear regarding trans people	Lack of gender recognition	Conduct advocacy meetings to review policies and laws related to trans people
	HCWs Teachers	HCWs and teachers understand SRHR and human rights of trans people	Lack of knowledge Negative attitudes and perceptions	Conduct training and orientation sessions on trans populations

Adolescent Girls and Young Women

Communication Goals: Increase access to and coverage of combination HIV prevention, testing, and treatment for AGYW and their sexual partners, and protect AGYW from GBV				
Target Group		Desired Outcome	Barriers	Key Activities
Primary Target Audience	AGYW 1524 years	Increased uptake of HIV prevention, treatment, and SRHR services by AGYW	Self-stigma Lack of self-confidence and ability to demand services Lack of negotiation skills for safer sex Inability of AGYW to report GBV	Implement a social media campaign on HIV prevention, treatment, SRHR, and comprehensive sexuality education Implement targeted mass media campaigns, including peer support Document and share emerging issues leading to low uptake of SRHR and HIV services among AGYW Orient youth NGOs and youth groups on HIV prevention, treatment, and access to SRHR services Mobilize youth NGOs and youth groups to conduct peer sessions on HIV prevention, treatment, and SRHR services

Secondary Target Audience	Parents	Parents understand and support adolescents to access HIV prevention and SRHR services AGYW are protected from GBVs	Lack of knowledge among parents on SRHR needs for AGYW Harmful cultural and social norms regarding youth access to HIV prevention and SRHR services Lack of knowledge	Implement a mass media campaign on adolescent SRHR needs using national and community radio stations and TV Conduct community outreach campaign using mobile videos and activation sessions Orient mother groups, religious groups, and other community structures on adolescent SRHR Orient Village Health Committee Action Groups on adolescent HIV prevention and access to SRHR services
Tertiary Target Audience	Traditional and religious leaders	Increased uptake of HIV prevention, treatment, and SRHR services by AGYW AGYW protected from GBV	Cultural and community norms that perpetuate early and child marriages Lack of knowledge Lack of supportive environment	Conduct advocacy meetings with traditional and religious leaders on early and child marriages Conduct mobilization campaigns among communities to act against child and early marriages Mobilize communities to work with district councils to develop community bylaws to end child and early marriages Implement a branded mass media campaign using community and national radio stations Implement GBV campaigns to promote reporting cases of GBV Conduct advocacy meetings among traditional and religious leaders, law enforcers, and judiciary on GBV
	HCWs	Youth access stigma-free services	Services for AGYW stigmatized by HCWs	Train youth groups to advocate for and engage with HCWs around young people's access to friendly and unstigmatized SRHR services Advocate for psychosocial services Advocate for youth-based NGOs as access points for essential SRHR services (condoms, HIVST, oral contraceptive pills, lubricants)

Sexually Transmitted Infections

Communication Goal: Increase demand and uptake of STI diagnosis and treatment services				
Target Group		Desired Change	Barriers	Key Activities
Primary Target Audience	KPs (MSWs, FSWs, trans people, MSM)	KPs routinely diagnosed and treated for STIs	Inadequate knowledge regarding STI diagnosis and treatment	Conduct outreach campaigns in hot spots to promote STI diagnosis and treatment among KPs and clients of SWs Conduct and implement annual STI awareness weeks
	CFSWs	CFSWs are accessing STI diagnosis and treatment services	Inadequate knowledge regarding STI diagnosis and treatment	Develop and implement a mass and social media campaign on STI diagnosis and treatment Conduct STI activation sessions in hot spots
	Prisoners	Prisoners are accessing STI diagnosis and treatment	Inadequate knowledge regarding STI diagnosis and treatment	Conduct integrated HIV prevention and SRHR health talks Advocate for availability of combination prevention methods in prison settings
Secondary Target Audience	Health care providers	HCWs must provide friendly/stigma-free services	Negative attitudes of HCWs toward KPs	Orient HCWs on the provision of KP-friendly services Conduct biannual advocacy meetings to track progress on KP-friendly services

Voluntary Medical Male Circumcision

Goal: Increase demand and uptake of VVMC among high-risk males (10–34 years) and newborns and infants				
Target Group		Desired Change	Barriers	Key Activities
Primary Target Audience	Men 15–49 years	Increased access to VMMC for men ages 15–49 years	Relating VMMC to religion and culture Fear of HIV and testing Limited knowledge of the MC procedure Misconception and myths around VMMC Not integrated and routinized in the service delivery	Scale up VMMC demand-creation campaign/multimedia. . Promote HTS through peer influencers . Promote a social media campaign on VMMC benefits. Sensitize the communities on misconceptions around VMMC. Conduct continuous barrier analysis on factors underpinning VMMC service uptake Advocate for integration and routinization of VMMC Advocate for VMMC scale-up in government health facilities Maximize interactive approaches to communication around VMMC among older men (betting houses/football gatherings)

			Service not available at a government facility	
Secondary Target Audience	Women and men of childbearing age Couples with male children	Increased demand for and utilization of VMMC	Lack of knowledge among circumcising communities	Sensitize communities on the benefits of VMMC. Improve the capacity of traditional mobilizers to scale up VMMC service uptake. Produce targeted creative materials to support VMMC services

Elimination of Mother-to-Child Transmission of HIV

Communication Goal: Increase uptake of and adherence to ARV drugs among pregnant women and mothers who are HIV positive				
Target Audience		Desired Change	Barriers	Key Activities
Primary Target Audience	HIV-positive pregnant women and breastfeeding mothers	Pregnant HIV-positive women and breastfeeding mothers are adhering to ARV drugs	Inadequate comprehensive knowledge of the benefits of ART among pregnant women Long distances to health facilities	Demand creation for EMTCT Develop and implement a media campaign (social media and community media) on the benefits of ART uptake and adherence among HIV-positive pregnant women and breastfeeding mothers. Scale up SMS for mHealth initiatives to remind women of the importance of EID
		HIV-positive women continue taking ARVs after giving birth	Lack of spousal support Stigma related to taking ARVs. Inadequate knowledge about the importance of adherence to treatment	Continuous ARV uptake Conduct one-on-one counselling among HIV-positive women. Develop and implement branded mass media campaigns to address stigma and promote treatment literacy
Secondary Target Audience	Males/spouses	HIV-positive women are accessing VL testing and monitoring services	Inadequate comprehensive knowledge among HIV-positive women on VL testing and its benefits	Demand creation for VL monitoring Develop and implement a branded media campaign (social media and community media) on the benefits and meaning of VL suppression
	Family and community	Family and community members are supportive of women	Lack of comprehensive knowledge of the importance	Family-based interventions

		who are HIV positive adhering to ART and accessing VL testing.	of family and community involvement Lack of comprehensive knowledge on EMTCT	Develop and implement a branded mass media campaign (social media and community media) on the benefits and meaning of VL suppression. Intensify door-to-door visits by community health cadres (health surveillance assistants, HIV diagnostic assistants, expert clients)

Pre-Exposure Prophylaxis

Communication Goal: Increase demand for and uptake of PrEP among high-risk populations				
Target Group		Desired Change	Barriers	Key Activities
Primary Target Audience	AGYW	AGYW have correct knowledge about PrEP. AGYW demand and access PrEP services	Inadequate knowledge regarding PrEP and its benefits Fear of side effects Low HIV risk perceptions Poor adherence due to the need for daily intake-Pill burden	Develop and implement a branded mass media campaign to provide correct information about PrEP and its benefits (refer to messages in PrEP Communication and Advocacy Strategy)
	FSWs	FSWs have correct knowledge about PrEP . FSWs who are HIV negative demand PrEP services	Inadequate knowledge regarding PrEP and its benefits Fear of side effects Low HIV risk perceptions Poor adherence due to the need for daily intake -Pill burden	Conduct training of PEs and navigators on PrEP for HIV prevention Support PEs and PNs (among FSWs) to conduct and intensify small group and one-on-one peer education sessions on PrEP
	MSM	MSM have correct knowledge about PrEP.	Negative influences of partners or immediate family members	Conduct training of PEs and PNs on PrEP for HIV prevention Support PEs and PNs (among MSM) to conduct and intensify small group and one-on-one peer education sessions on PrEP

		MSM who are HIV negative demand PrEP services	Fear of stigma associated with PrEP because it looks like ART for HIV The potential for PrEP to promote risky sexual behaviour	
	Sero-different couples	Sero-different couples have correct knowledge about PrEP. Sero-different couples can demand PrEP services	Negative influences of partners or immediate family members Fear of stigma associated with PrEP because it looks like ART for HIV	Conduct targeted door-to-door visits to conduct PrEP talks among sero-different couples. Include sero-different couples in the branded mass media campaign to provide correct information about PrEP and its benefits (refer to messages in PrEP Communication and Advocacy Strategy)
	Trans people	Trans people have correct knowledge about PrEP and its benefits. Trans people can demand PrEP services	Negative influences of partners or immediate family members Fear of stigma associated with PrEP because it looks like ART for HIV The potential for PrEP to promote risky sexual behaviour	Conduct training of PEs and PNs on PrEP for HIV prevention Support PEs and PNs (among trans people) to conduct and intensify small group and one-on-one peer education sessions on PrEP
Secondary Target Audience	Spouses Parents		Negative influences of partners or immediate family members Fear of stigma associated with PrEP because it looks like ART for HIV The potential for PrEP to promote risky sexual behaviour	Develop and implement a branded mass media campaign to provide correct information about PrEP and its benefits (refer to messages in PrEP Communication and Advocacy Strategy)

Tertiary Target Audience	PrEP providers	HCWs are providing gender-affirming services	Inadequate knowledge about the provision of gender-affirming services	Conduct training/orientation among HCWs on the provision of gender-affirming sessions related to PrEP

Treatment as Prevention

Communication Goal: Increase the number of people who go for HIV testing to access TasP				
Target		Desired Change	Barriers	Key Activities
Primary Target Audience	KPs Sero-different couples. General population	Individuals know about and go for HIV testing to access treatment for prevention. Individuals are aware of the importance of treatment for HIV prevention. Untested individuals are willing to access HIV testing	Inadequate knowledge of TasP	General population Develop and implement a branded mass media campaign on TasP (jingles, talk shows, leaflets) Conduct small-group discussions with targeted groups on treatment as prevention. Train peer cadres on treatment literacy

Blood Safety

Communication Goal: Increase the number of people donating blood at least four times a year.			
Target Group	Desired Change	Barriers	Key Activities
Prospective blood donors	Individuals donate blood at least four times a year	Misconceptions regarding blood transfusion Inadequate knowledge about the process of blood transfusion Inadequate knowledge about the importance of blood donation	Conduct health talks on blood transfusion targeting eligible school-going children and universities. Conduct community activation and mobilization campaigns on blood transfusion. Conduct advocacy meetings with religious leaders to encourage their faithful to donate blood. Develop and implement a mass and social media campaign on blood transfusion

Annex 2. M&E Results Frameworks for the HIV Prevention Framework

Input[4]	Activities/Processes[5]	Outputs[6]	Intermediate Results (Outcomes[7,8])	HIV Prevention Strategic Goal	NSP Goals and Objectives (2020–2025)
Budget Human resources Time (time invested and time taken to achieve results) Equipment Existing infrastructure Partnerships/ Collaborations	-Improve SBCC -Strengthen systems and improve quality -Stakeholder and private sector engagement and collaborations -Develop standard operating procedures -Capacity building for leaders -Technical assistance	-Increased availability of condoms -Improved quality of services in both public and private facilities -Improved leadership and coordination of the condom program -Improved supply chain management	IR 1: Increased use of condoms among males and females during high-risk sexual encounters, including condoms and lubricants for KPs	Reduce the annual number of new HIV infections to 8,000 by the end of 2025, from a baseline of 19,000 in 2021	NSP goal: To contribute toward ending AIDS as a public health threat in Malawi by 2030 Objectives: Reduce new HIV infections from 33,000 in 2019 to 11,000 in 2025.

[4]Inputs are resources going into HIV Prevention activities.

[5]Inputs are mobilised through these actions. Each activity will have its own set of inputs and outputs.

[6]These are immediate results from each activity.

[7]These are medium- to long-term expected results (Contributing to the HIV Prevention strategic goal).

[8]These are long-term expected results (impact) related to the NSP Goals and Objectives.

	-Capacity building for HCWs/service providers -Implement the VMMC communication strategy -Strengthen health systems (M&E and data management) -Introduce a systematic electronic information management and communication system for early infant male circumcision (EIMC)	-Increased access to VMMC in public and private facilities -Increased demand generation for VMMC -Improved health systems -Improved behaviours	IR 2: Increased VMMC coverage among males ages 10–34 years and development of MC services for newborns and infants		Reduce HIV- and AIDS-related morbidity and mortality. Reach 95-95-95 treatment targets. Improve the quality of HIV services. Build resilient health and social welfare systems for effectively responding to the HIV and AIDS epidemic.
	- Strengthen governance and coordination - Build capacity of HCWs (service providers) - Implement the PrEP communication strategy - Strengthen health systems (PrEP, M&E, and supply chain)	- Improved system readiness for implementing PrEP in high-risk populations - Increased PrEP demand, acceptance, and adherence -Improved availability of supplies	IR 3: Scale-up of PrEP considering its feasibility and cost-effectiveness in specific subpopulations at high risk of HIV infection.		

	- Establish drop-in centres (DICs) and KP-designated corners (public and private health facilities) - Recruit and build capacity of PEs, PNs, community leaders, and outreach workers	-Expanded differentiated models of service delivery at a wider range of venues -Greater involvement of private sector service delivery -Coordinated SBCC strategy	IR 4: Increased coverage of tailored combination HIV prevention packages among high-risk subpopulations, including AGYW, KPs, and HIV serodifferent couples		
	- Size estimations and IBBS	-Development of a cadre of PEs for trans people, MSWs, PWID -Guidance documents -Community-led interventions	IR 5: Expanded activities among KPs, including trans people, MSWs, PWID, and incarcerated individuals		

	- Strengthen integrated HIV testing for infants and their mothers/fathers with other maternal health services -Establish family-based interventions, "MTCT-Plus" . -Engage and promote expert clients/mentor mothers in service provision at the health facility/community level -Improve diagnostics by integrating POC instruments (GeneXpert machine) into the conventional laboratory	-Reduce number of women and infants contracting HIV during antenatal and breastfeeding period -Provide treatment, care, and support to infected mothers and infected and exposed infants to ensure adherence to ART and infant feeding method	IR 6: Increased ART coverage among HIV-infected pregnant and postpartum women and HIV-infected male partners of HIV-uninfected pregnant and postpartum women		

	-Implement state-of-the-art BCC interventions (including social media) addressing individual and interpersonal-level barriers - Implement community mobilization activities addressing community-level barriers - Roll out advocacy initiatives aimed at structural barriers	-Increased demand for and uptake of priority HIV prevention packages -Increased adoption of safer sexual behaviours and reduction in risky sexual behaviours -Improved structural environment that facilitates utilization of HIV prevention services	IR 7: Development and implementation of a coordinated SBCC strategy covering all the combination prevention pillars		
	- Implement one M&E system for national HIV response - Invest in standardized digital health systems - Strengthen decentralized M&E structures and systems and community linkages - Strengthen research, innovation, and dissemination	-Improved M&E systems to promote evidence-based programming and quality assurance -Strengthened community-based monitoring systems	IR 7: Improved M&E system, data collection, and health management information system (HMIS)	Improved reporting of HIV prevention results to inform quality programming and response	Improved and standardized one M&E system that is integrated and optimized. Digital health information systems for effective prevention monitoring and evaluation
	-CBO mapping, advocacy for funding, engaging community leaders,	-Unified, decentralized, people-centred HIV	IR 8: Improved leadership and coordination between		

	strengthening district-level mechanisms, developing comprehensive SBCC strategy -Liaise with donors, conduct regular M&E -Create mechanisms for the dissemination of HIV prevention policies, strategies, and procedures	prevention programme -Resource management system that ensures equitable distribution of essential financial, technical, and material resources, quality, and coverage -Multisectoral, multilevel policy implementation and monitoring	combination prevention pillars		

Assumptions underlying the results framework:

The MOH, NAC, and implementing partners will fully support the implementation of the HIV Prevention Framework (2023–2027).

The proposed interventions herein will be implemented with rigor and require human and financial resources.

SBCC interventions and messages will be adapted and tailored to specific local contexts to optimize the required efficacy and impact.

The HIV Prevention Framework (2023–2027) will be coordinated and implemented as planned (i.e., fidelity and integrity achieved).

M&E activities will have the full support of government, the coordinating body (NAC), and implementing partners as specified in the strategy.

Annex 3: Results Indicator Matrix for HIV Prevention 2022–2026

No	Key Performance Indicators	Target	Data Source	Data Collection Frequency
A	Treatment as Prevention			
A.I	Proportion of PLHIV on ART that is virally suppressed, disaggregated by age and population group	95%	DHAMIS	Quarterly
A.2	Proportion of PLHIV with a VL test done	95%	DHAMIS, LIMS	Quarterly
A.3	Proportion of newly diagnosed clients linked to ART	95%	DHAMIS	Quarterly
A.4	Proportion of clients who defaulted and were reinitiated on treatment	95%	DHAMIS	Quarterly
A.5	Number of people newly diagnosed as HIV positive reported annually	11,000	Annual progress report on HIV and AIDS response MPHIA Survey report	Annually
A.6	Number of VL tests done annually (Note that there is an inconsistency between the measure of the indicator and the related target — the indicator is looking at a number, while the relevant target is looking at a proportion.)	95%	DHAMIS	Quarterly
A.7	Percentage of PLHIV on ART who had VL monitoring six months after initiation of ART	95%	DHAMIS	
A.8	Proportion of PLHIV reached with T=T messages	60%	DHS	TBD
A.9	Percentage of HCWs who provide treatment literacy on medication and psychosocial support for adherence	60%		
A.10	Number of ART patients with no clinical contact (or ARV drug pick-up) for greater than 60 days since their last expected contact who restarted ARVs within the reporting period (Note that there is an inconsistency between the measure of the indicator and related target — the indicator is looking at a number, while the relevant target is looking at a proportion.)	5%	MDHS	TBD
A.11	Number of PLHIV ages 15+ retained in care (Note that there is an inconsistency between the measure of the indicator and related	95%	DHAMIS, HMIS, DHIS2	Quarterly

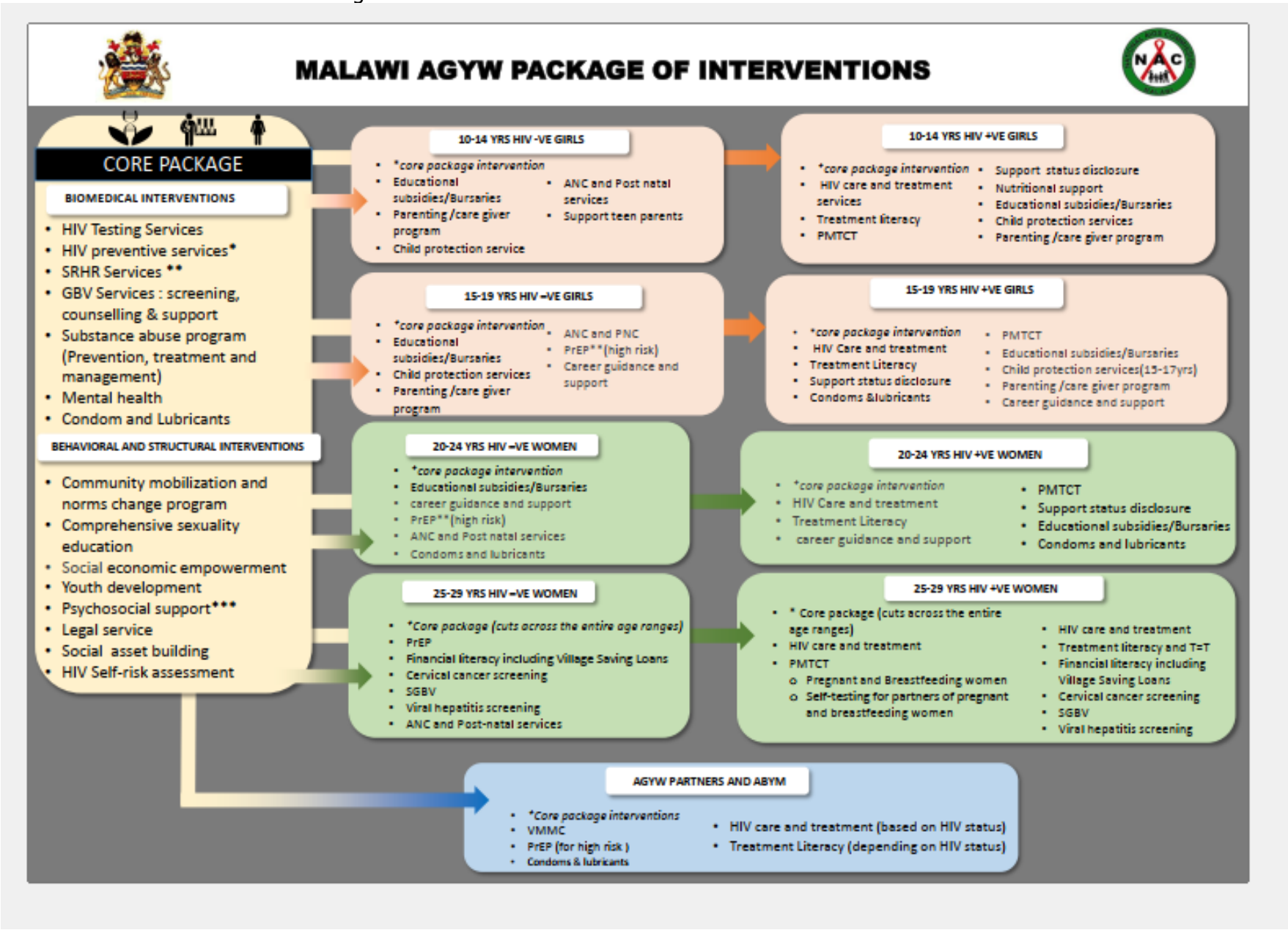
	target — the indicator is looking at a number, while the relevant target is looking at a proportion.)			
A.12	Proportion of PLHIV with knowledge of the clinical benefits of treatment monitoring	95%	MDHS	TBD
B	Comprehensive Condom Programming			
B.1	Percentage of women and men ages 15–49 years who reported using a condom at last sexual intercourse with a nonmarital, non-cohabitating partner (*sex and age*)	80%	DHS	TBD
B.2	Percentage of men and women ages 15–49 years who know that consistent and correct use of condoms reduces the risk of HIV acquisition	90%	DHS	TBD
B.3	Number of male and female condoms distributed annually (*disaggregated by target group*). (There may be a need to disaggregate the targets for male and female condoms.)	Female condoms: 675,000 Male condoms: 146,192,348	HMIS, DHIS2	Quarterly
B4	Proportion of serodifferent couples reporting having used condoms correctly and consistently	95%	DHS	TBD
C	Voluntary Medical Male Circumcision			
C.1	Number of male MCs performed according to national guidelines	900,000	HMIS, DHIS2	Quarterly, annually
C.2	Percentage of circumcised males tested for HIV as part of VMMC services	95%	HMIS, DHIS2	Quarterly, annually
C.3	Percentage of population with correct knowledge of the benefits and risks of VMMC	60%	DHS, special studies	Quarterly, annually
D	Adolescent Girls and Young Women			
D.2	Percentage of in-school young people ages 10–24 years reached with life-skills education (*disaggregated by age and gender*)	60%	DHS, special studies	TBD
D.4	Percentage of young people ages 10–24 years with comprehensive knowledge of HIV prevention	60%	DHS	TBD

D.5	Percentage of young people ages 10–24 years living with HIV and on ART (*disaggregated by age and gender*)	95%	HMIS, DHIS2	Quarterly, annually
D.6	Percentage of young people ages 10–24 years on ART and virologically suppressed (*disaggregated by age and gender*)	70%	HMIS, DHIS2	Quarterly, annually
E	Key Populations			
E.1	Percentage of KPs (FSWs, MSWs, prisoners, MSM, and trans people) who tested for HIV in the past 12 months and received their results (*disaggregated by KP*)	95%	HMIS, DHIS2	Quarterly
E.2	Percentage of KP individuals (FSWs, MSM, and trans people) enrolled on ART who are virologically suppressed at six and 24 months post-ART initiation	70%	HMIS, DHIS2	Quarterly
E.3	Number of KP individuals who were offered PrEP	36,315	HMIS, DHIS2	Quarterly
E.4	Percentage of newly diagnosed HIV-positive KP individuals (FSWs, MSWs, prisoners, MSM, and trans people) initiated on ART	95%	HMIS, DHIS2	Quarterly
E.5	Percentage of prisoners who have been tested for HIV and received results	90%	HMIS, DHIS2	
E.6	Percentage of KP individuals reached with HIV prevention intervention with a defined minimum package of services	70%	DHS, BBSS	Quarterly
E.7	Percentage of prisons implementing full minimum standard medical package (three-phase intervention model)	50%	Special studies, HMIS, DHIS2	
E.8	Prison-specific HIV policy developed	1	NAC	Annually
F	Pre-Exposure Prophylaxis			
F.1	Number of KP individuals and members of other high-risk populations who accessed PrEP in Malawi	36,315	HMIS, DHIS2	Quarterly
F.3	Percentage of eligible FSWs who initiated oral ARV PrEP during the reporting period	70%	DHS, special studies	Quarterly
F.4	Percentage of eligible AGYW who initiated oral ARV PrEP during the reporting period	70%	DHS, special studies	Quarterly
F.5	Percentage of eligible MSM who initiated oral ARV PrEP during the reporting period	70%	DHS, Special studies	Quarterly

F.6	Percentage of eligible sexual partners of HIV-positive people who initiated oral ARV PrEP during the reporting period	70%	DHS, special studies	TBD
F.13	Percentage of facilities with stock-outs of essential commodities (i.e., TDF/3TC, Determine, Unigold, HepB tests)	10%	HMIS, DHIS2	Quarterly, annually
F.15	Percentage of the population with correct knowledge about PrEP (pill to prevent HIV, taken daily, safe, can be taken during "seasons of risk")	60%	DHS, special studies	TBD
G	Elimination of Mother-to-Child Transmission of HIV			
G.1	Percentage of pregnant and postpartum women who tested for HIV and received results in the past 12 months	95%	HMIS, DHIS2	Quarterly, annually
G.2	Percentage of HIV-infected pregnant and lactating mothers initiated on ART in the past 12 months	95%	HMIS, DHIS2	Quarterly, annually
G.3	Percentage of HIV-infected pregnant and lactating mothers screened and treated for syphilis in the past 12 months	95%	HMIS, DHIS2	Quarterly, annually
G.4	Percentage of HIV-infected pregnant and lactating mothers initiated on ART and retained in HIV care at 12 and 24 months	95%	HMIS, DHIS2	Quarterly, annually
G.5	Percentage of pregnant and lactating mothers with LDL in the past 12 months	95%	HMIS, DHIS2	Quarterly, annually
G.6	Percentage of HIV-exposed infants who received virological results for HIV within two months of birth	95%	HMIS, DHIS2	Quarterly, annually
G.7	Percentage of infants born to HIV-infected women discharged uninfected at 24 months of age (i.e., 24-month infant HIV-free survival).	95%	HMIS, DHIS2	Quarterly, annually
G.8	Percentage of partners of pregnant and breastfeeding mothers who are tested in the past 12 months	95%	HMIS, DHIS2	Quarterly, annually
H	Sexually Transmitted Infections	Target	Source	Frequency
H.1	Percentage of STI patients with HIV status ascertained	95%	HMIS, DHIS2	Quarterly, annually
H.2	Percentage of ANC clients tested for syphilis	95%	HMIS, DHIS2	Quarterly, annually
H.3	Number of KP individuals tested and treated for syphilis.			

H.4	Proportion of health facilities with at least one health professional trained in STI syndromic management	95%	HMIS, DHIS2	Quarterly, annually
H.5	Percentage of women living with HIV screened for cervical cancer	95%	HMIS, DHIS2	Quarterly, annually
I	Blood Safety	Target	Data Source	Frequency
I.1	Number of blood collections collected annually against the target (103,156)	103,156	MBTS	Quarterly, annually
I.2	Percentage of blood units screened for HIV, syphilis, hepatitis B, hepatitis C against the total blood units dispatched to facilities	100%	MBTS	Quarterly, annually
I.3	Proportion of safe blood and blood products dispatched from MBTS against facility orders	99%	MBTS	Quarterly, annually
J	Monitoring and Evaluation	Target	Data Source	Frequency
J.1	Number of M&E systems in place for managing HIV programs	1	NAC	Annually
J.2	Number of coordinating structures for managing HIV prevention programs	1	NAC	Annually
J.3	Number of funding coordination mechanisms for managing HIV prevention funds	1	NAC	Annually
J4	Number of local councils having management and data review meetings per schedule	34	NAC	Quarterly
J.5	Number of national research dissemination workshops conducted	10	NAC	Annually
J.6	Number of TWGs established and actively contributing to prevention goals (minutes of meetings, outputs)	7	NAC	Annually
J.7	Number of program evaluations conducted	2	NAC	Annually
J.8	Proportion of national funding allocated to the National HIV Prevention Program	30%	NAC	Annually

Annex 4. AGYW Minimum Service Package



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